Should hospitalists staff RRTs?

Should hospitalists play a role on the rapid response teams (RRT) that Institute for Healthcare Improvement’s (IHI) President Donald Berwick, MD, MPP, promoted during his speech kicking off the IHI’s 100,000 Lives campaign?

Hospital RRTs—also called medical emergency teams—quickly assess and act at the first signs of patient decline.

One year after Berwick’s call, there is growing evidence that RRTs are enabling healthcare practitioners to reduce inpatient mortality rates by catching respiratory, cardiac, and other problems before the situation becomes critical.

Introduced in 1995 by an Australian hospital, the RRT concept quickly spread to other countries due to its proactive approach to saving lives. U.S. News and World Report in July reported that Dandenong Hospital in Australia cut cardiac arrests by 50% and lowered the death rate in patients who had an arrest from 77% to 55% by using RRTs (www.usnews.com/usnews/health/articles/050718/18best.rrt.htm).

In light of such positive results, the question for many hospitals capable of creating RRTs is not whether it feasible to do so, but how to staff the teams.

In its Getting Started Kit: > p. 2

Hospitalists vs. inpatient rounders

Defining roles and expectations in a growing field

As hospital medicine enters only its second decade, healthcare facilities of all sizes continue to grapple with defining the roles, responsibilities, and expectations of hospitalists.

One such evolutionary growing pain is getting what you pay for when it comes to implementing a hospitalist program. Hospital administrators must ensure that their programs enable hospitalists to be truly integrated within the organization, rather than serve as inpatient rounders, or internists without primary care offices.

At the same time, program directors must ensure that they provide the necessary support—from hiring additional support staff such as case managers to offering flexible schedules when possible—so hospitalists can provide optimal economic value for the facility.

According to Stacy Goldsholl, MD, national medical director for Irvine, CA–based hospitalist company Cogent Healthcare (www.cogenthealthcare.com) and a board member of the Society of Hospital Medicine (SHM), > p. 7
Rapid Response Teams, the IHI (www.ihi.org) recommends that organizations carefully consider their resources and culture when choosing team members. Further, the institute recommends building on existing relationships and practice patterns to achieve success.

The IHI suggests that the following two-, three-, or four-practitioner teams work well:
- Intensive care unit (ICU) registered nurse (RN) and respiratory therapist (RT)
- ICU RN, RT, intensivist, and medical resident
- ICU RN, RT, and intensivist or hospitalist
- ICU RN, RT, and physician assistant (PA)

HMA asked hospitalists and hospitalist program directors to comment about RRT staffing issues. Respondents noted the following key questions as relevant in deciding whether hospitalists are the right physicians to staff or lead RRTs:
- Does your current staffing model enable hospitalists to participate (e.g., does your hospitalist program offer 24/7 coverage)?
- How will RRT memberships affect the hospitalists’ overall schedule?
- How will RRT members be compensated for their participation, if at all?
- Is it likely that your organization will provide support, financial or otherwise, for the RRT?
- Would placing a practitioner other than a physician (e.g., PA, nurse practitioner [NP], or RT) on the RRT make better sense at your facility?

UCSF Department of Medicine

Andrew Auerbach, MD, MPH, is an assistant professor of medicine at the University of California at San Francisco (UCSF), which currently employs 18 hospitalists, and a clinician-researcher in UCSF’s hospitalist group. He spoke during the First International Conference on Medical Emergency Team Responses in Pittsburgh, held on June 24–25 and sponsored by the University of Pittsburgh Medical Center), and is coauthor of a consensus statement about RRTs for the First International Conference, slated for release in 2006.

Staffing issues

Auerbach says hospitalists, especially those working at facilities offering 24/7 coverage, are a natural fit for RRTs, and are already doing a great deal of consultation and cross-coverage on acute changes in patients’ status. “Essentially, hospitalists have been doing a lot of RRT work without it being called RRT work.”

Despite giving this additional work a name, staffing RRTs with hospitalists may not necessarily represent a big change in hospitalists’ job description, according to Auerbach. However, “at large hospitals, it could be a fair amount of additional work,” he adds.

It is unclear whether RRTs benefit from hospitalists’ expertise, Auerbach cautions, as no studies have been done at hospitals that staff RRTs with hospitalists. With the exception of one RRT study at a Pittsburgh teaching hospital, “Almost all of the studies have been done in Australia,” Auerbach says. In addition, because the mean length of stay (LOS) in the Australian hospital studies is seven to 10 days—twice as long as the average LOS in the United States—it is difficult to extrapolate the data to reach any conclusions about RRTs in our nation’s hospitals.

Another gray area is whether RRTs staffed with a combination of PAs, NPs, or RTs without a physician member can be successful, says Auerbach. Despite the fact that the IHI advocates such teams, the results are unstudied. “There are no data out there to say [those models] are not going to work, and at present hospitals are still making their best guess about what will work best for their staff and their organization.”

He notes that some Australian and U.K. studies have shown that as many as 20% of patients warranting a rapid response need to be intubated or receive CPR—an important fact for hospitals to consider when staffing RRTs with hospitalists, especially those fresh out of residency who may not have much experience. “The gold standard would be to have a physician at the bedside—and that physician should be able to intubate, manage noninvasive ventilation, and perform cardiopulmonary resuscitation.”
Compensation
Auerbach says it appears a hospitalist can bill an ICU code or at least a consultation code for RRT visits to nonmedical patients, but the details are still uncertain in situations where patients are already on a medical service (and have been seen by another internist on the same day). Regardless, he says, “At most hospitals, unless there is a very high volume of RRT work, hospitalists are staffing RRTs as an added responsibility.”

For hospitals striving to meet the IHI recommendations, this is just one more point to consider when negotiating with hospitalists.

Tip: Refer to pp. 5–6 for sample forms to help your facility develop a more structured or “scripted” approach to making RRT calls and to evaluate the team(s) once they are in place. (Note: These forms are taken from Rapid Response Teams: Proven Strategies for Successful Implementation, published by HCPro, Inc., in Marblehead, MA. See the note at the end of the story for more information about this book.)

Milford (CT) Hospital
Richard E. Rohr, MD, FACP, is director of the four-year-old hospitalist service at Milford Milford Hospital, which employs five hospitalists. He says that although academic medical centers generally use medical residents to provide rapid response services, hospitalists should be at the core of the RRT in any nonteaching hospital.

Staffing issues
A primary reason for including hospitalists is that they have key assessment and management skills enabling them to deal with the changing conditions of inpatients. However, Rohr also notes, “The political issues of having another physician intercede in the care of a failing patient appear to have pushed RRTs in the direction of using nurses and [RTs]. Other physicians must understand that patient safety takes precedence over their autonomy in practice.”

Even though using RRTs without a physician on the team is appropriate and necessary in some cases, Rohr says a single physician—as opposed to a team—usually can provide the fastest and most effi-

Tips for success in selecting RRT members
- Select team members with good interpersonal skills
- Explicitly define roles and responsibilities. For example, the team will
  - respond to calls within five minutes
  - collaborate with the primary patient care team
  - assess the patient and, together with the primary nurse, communicate this assessment to the patient’s attending physician
  - initiate protocols as defined
  - document calls in the RRT log
- Consider an RRT job description, which may require the team member to
  - have mentoring skills
  - have at least five years’ intensive care unit experience
  - collaborate with other departments
- Train RRT members as a team in
  - situation awareness
  - briefings
  - anticipating and communicating planned and possible events
  - cross-checking and verifying
  - providing follow-up
- Consider formal training to help RRT members
  - prioritize assessment needs for the critically ill and injured patient
  - select appropriate diagnostic tests
  - identify and respond to significant changes in the unstable patient
  - recognize and initiate management of acute life-threatening conditions
  - determine the need for expert consultation/patient transfer and prepare the practitioner for optimally accomplishing transfer

Editor’s note: This information was taken from Rapid Response Teams: Proven Strategies for Successful Implementation, published by HCPro Inc. in Marblehead, MA. Go to www.hcmarketplace.com/prod-3650.html for details.
cient assessment of patients showing early signs of trouble. This system is used at Milford Hospital.

“The system would be much more effective if nurses [were] empowered to call a hospitalist at the earliest sign of trouble for any patient in the hospital because many episodes of intensive care could be avoided,” he adds.

Compensation
The best method for paying hospitalists for their involvement on RRTs is still up in the air, Rohr says. “It’s possible to bill for critical care services if provided. Less severe cases should be compensated by the hospital, possibly on a per-event basis, or by providing an annual amount to provide coverage,” he adds.

St. Joseph’s Hospital, Bangor, ME

Kenneth G. Simone, DO, is administrative director for Northeast Inpatient Medical Services, which employs eight hospitalists and has served St. Joseph’s Hospital since 1996. He is also founder and president of Hospitalist and Practice Solutions in Brewer, ME.

Staffing issues
Simone says that for hospitals opting to staff RRTs with a physician member, hospitalists are a good choice due to their
- availability. They are generally in the hospital for more hours than any other specialists, with the exception of emergency department (ED) physician.
- skill set as specialists in hospital medicine.
- intimate knowledge of the hospital workings/system and staff.

He adds, “Consider that if the hospitalist practice is successful and highly utilized, the odds are that hospitalists will know the patient [in need of rapid response].”

According to Simone, a primary factor in determining whether to staff RRTs with hospitalists is whether the program provides 24/7 in-house coverage.

He adds that a dedicated hospitalist program should be adequately staffed before asking hospitalists to participate on RRTs. “If a program is traditionally understaffed or the hospitalists are overworked, I would recommend against using the hospitalists on RRTs to avoid burnout and a potential substandard outcome,” he says.

For small or understaffed hospitalist groups, Simone recommends considering a “split RRT” on which hospitalists and possibly intensivists are used during the day and ED physicians staff the team at night. However, he cautions that split teams might suffer from issues of continuity and familiarity with the team and system.

Compensation
Simone agrees that determining how to compensate hospitalists for their work on RRTs is a difficult question. “Participation could be considered an added-value benefit hospitalists bring to the table. Thus, if a hospitalist group is subsidized, a portion of the funding for RRT participation can be allocated or justified within this subsidy,” he says.

According to Simone, any additional stipend paid out could be based on the scope of the service (e.g., what specific role does the RRT play in the institution and what is the role of the hospitalist on the team) or on utilization frequency, which would require the facility to generate and regularly review a history of how often the RRT is called into action.

Another consideration is to allow the hospitalist to bill for the physician services provided in addition to offering a stipend, he adds.

“Hospitalists should [welcome] being physician leaders within the institution. Serving on the RRT will also establish and reinforce the value that hospitalists bring to the hospital, medical arena, and community,” Simone says.

Cogent Healthcare: Hospitalist contracts in 16 states

Ronald Greeno, MD, FCCP, founder and chief medical officer of hospitalist company Cogent Healthcare (www.cogenthealthcare.com), based in Irvine, CA, says, “You will probably get
### Sample SNAP call script

<table>
<thead>
<tr>
<th>S</th>
<th>N</th>
<th>A</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summarize:</strong></td>
<td><strong>Note:</strong></td>
<td><strong>Analyze:</strong></td>
<td><strong>Propose Action:</strong></td>
</tr>
<tr>
<td>State your name, unit:</td>
<td></td>
<td></td>
<td>I suggest or request that you:</td>
</tr>
<tr>
<td>I am calling about &lt;patient name, location, and brief summary of situation&gt;.</td>
<td></td>
<td></td>
<td>&lt;say what you would like to see done&gt;</td>
</tr>
<tr>
<td>The patient's code status is &lt;code status&gt;. The patient's vital signs are:</td>
<td></td>
<td>This is what I think the problem is:</td>
<td><strong>Transfer the patient to critical care</strong></td>
</tr>
<tr>
<td>Pressure: _______ Pulse: _______</td>
<td>Respiration: _______ Temperature: _______</td>
<td>&lt;say what you think is the problem&gt;</td>
<td><em>come to see the patient at this time.</em></td>
</tr>
<tr>
<td>over 200 systolic over 130</td>
<td>less than 6 over 100</td>
<td>The problem seems to be cardiac infection neurologic respiratory ____</td>
<td><strong>Talk to the patient or family about code status.</strong></td>
</tr>
<tr>
<td>less than 90 systolic less than 40</td>
<td>less than 96</td>
<td></td>
<td>Contact Rapid Response Team member.</td>
</tr>
<tr>
<td>30 mmHg below usual</td>
<td>over 24</td>
<td>Ask for a consultant to see the patient now.</td>
<td><strong>Do any tests like CKR, ABG, EKG, CBC, or BMP?</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Others?</td>
</tr>
<tr>
<td>The patient is not or is on oxygen.</td>
<td></td>
<td>If a change in treatment is ordered then ask:</td>
<td><strong>How long to you expect this problem will last?</strong></td>
</tr>
<tr>
<td>The patient has been on ____ (limin) or (%) oxygen for ____ minutes (hours).</td>
<td></td>
<td>How often do you want vital signs?</td>
<td><strong>If the patient does not get better when would you want us to call again?</strong></td>
</tr>
<tr>
<td>The oximeter is reading ____%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The oximeter does not detect a good pulse and is giving erratic readings.</td>
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</table>


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Sample rapid response team (RRT) evaluation form

Rapid Response Team (RRT) Evaluation Form

Date of Event: ______ Time of Event: ______ Place of Event: (Dept/Unit of Patient): _______

Patient Name: _________ Medical Record #: _________ Acct #: _________
(6 digit) (8 digit)

Please answer the following questions with respect to the RRT Event.
The Primary Nurse of the patient should complete this form and return it within 24 hours.
Please answer each question and mark your responses with an “X” when appropriate.

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>Disagree Strongly 1</th>
<th>Disagree Slightly 2</th>
<th>Neutral 3</th>
<th>Agree Slightly 4</th>
<th>Agree Strongly 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The RRT arrived in a timely manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The RRT nurse was knowledgeable and efficient in assessing and implementing care needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The RRT respiratory care therapist was knowledgeable and efficient in assessing and implementing care needs.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Communication to and from the RRT nurse and/or respiratory care therapist was effective in facilitating the delivery of care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The RRT was courteous and helpful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patient outcome was improved because of RRT assistance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>I worked collaboratively with the RRT and the attending physician/resident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>In working with the RRT I feel more comfortable and confident in managing patient in pre or potential crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The RRT helped me to learn something new or something I should have done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>The RRT helped me to see or understand the &quot;big picture&quot; on managing the patient’s care.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>EDUCATION: (Briefly describe what you learned)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>PROCESS IMPROVEMENT: (Briefly describe a change in a patient care process that could help improve patient care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>ADDITIONAL COMMENTS:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary Nurse (Print name) ___________________ (Signature) ___________________
Please return completed form to Nurse Manager, QET 4C within 24 hours of event.

Source: Adapted by Queen’s Medical Center in Honolulu from Missouri Baptist in Memphis, TN. Reprinted with permission.
there is a difference between models in which physicians are inpatient rounders versus “real” hospitalists. Failing to create a true hospitalist program could be counterproductive to the original goals (e.g., decreasing length of stay [LOS] and improving overall patient care) that your facility identified as reasons for instituting a hospital medicine program in the first place.

Goldsholl spoke October 17 during the Fall 2005 Hospitalist Continuing Medical Education Series in Atlanta, sponsored in part by Hospitalist Conferences USA and Today’s Hospitalist. Her keynote address, “Hospitalist or Inpatient Rounder? Implications for Length of Stay,” outlined various factors that distinguish a true hospitalist from an inpatient rounder. She noted that hospitalists are

- incorporated into the hospital’s organizational culture
- champions of patient safety and quality
- leaders of evidence-based best practices
- captains of patient care and patient advocacy
- documentation experts for maximum hospital reimbursement
- resource utilization and LOS managers (which includes real-time admitting and the ability to make second daily patient visits)

Alternatively, Goldsholl characterized inpatient rounders as physicians who typically

- are not responsible for real-time admitting
- do not make second daily patient visits
- are not integrated within the hospital organization
- are not part of a 24/7 scheduling model
- are not able to maximize savings related to LOS by implementing all of the above factors

Most important, rounders are usually compensated based on productivity alone—a model that does not always benefit the hospital, she said. “If your hospitalists are paid [based on] productivity alone, what is their incentive to see a patient a second time? Or to decrease LOS? You are financially shooting yourself in the foot.” To demonstrate this point, she noted that the relationship between a hospitalist’s professional fees and LOS is directly proportional. “If you increase LOS, you increase your professional fees.”

**Gauging hospitalists’ overall value**

Although the SHM’s definition of hospitalists (“Physicians whose . . . activities include patient care, teaching, research, and leadership related to hospital medicine”) is not descriptive of specific tasks, Goldsholl noted that the list of demands placed on hospitalists only seems to grow with time. It is not surprising for what she notes is “the single fastest growth of a specialty in the history of medicine.”

“The days of hospitalists demonstrating their value through LOS savings [alone] are gone,” she said. Today, they are increasingly expected to show that they provide better patient safety results and overall improved quality of care, according to Goldsholl.

A veteran in setting up successful hospitalist programs, Goldsholl said more medical staff leaders are making the connection that an inpatient rounder cannot bring the advantages that true hospitalists can. “I get a very acute sense from hospital administrators that they want hospitalists [who are local, incorporated into the culture, and champions of patient safety],” she said.

It’s clear that hospitalists are now expected to be assertive enough to be strong patient advocates, she added.

**Real-time admitting**

Goldsholl singled out real-time admitting as one of the most important advantages a true hospitalist brings to the hospital. “There is a new sentiment that [hospital administrators] want hospitalists to admit in real time.” It is a point that is closely related to another current debate in hospital medicine—whether 24/7 hospitalist staffing is worth the price. According to experts, there is not yet enough comprehensive data to prove that 24/7 coverage positively affects patient outcomes.
Rounders

In hospitals that do not have 24/7 hospitalist coverage, other staff physicians or residents can perform the real-time admitting during off-hours. However, according to Goldsholl, the cost of a 24/7 hospitalist program may be justified for community hospitals and other facilities without access to residents and interns to help with off-hours admitting because hospitalists could eliminate costly delays in admission.

Goldsholl cited an unpublished case study that she conducted at a hospital in Saginaw, MI. The results showed that a group of in-house, shift-based hospitalists providing 24/7 coverage attended to 1,530 patients and achieved a case mix index–adjusted LOS of 2.97. Meanwhile, a group of traditional hospitalists (i.e., not employed by the hospital) attended to 1,852 patients and achieved a case mix index–adjusted LOS of 4.00. The third group in the study, traditional internists, attended to 2,644 patients and achieved a case mix index–adjusted LOS of 4.50.

In addition to real-time admitting, Goldsholl sees a growing expectation for hospitalists to perform real-time patient intervention. With regard to immediacy in reviewing test results, she pointed out that hospital-employed hospitalists in a 24/7 program “can follow-up on an ultrasound report as soon as they get it, not wait until the next morning.”

Second daily visits

Second daily visits to hospitalized patients are another hot topic within the larger debate of inpatient rounders versus real hospitalists.

According to Goldsholl, a certain population of patients (she estimates approximately 30%) benefits from a second daily visit by the hospitalist. The visit could encompass anything from an actual clinical intervention to time spent meeting with a patient’s family or another practitioner regarding the case. Regardless, she said, it is time that cannot be attributed or billed to another patient.

It is without question that this feature is becoming one of the standards of a true hospitalist model, according to Goldsholl.

On the flip side, practitioners considered inpatient rounders do not generally make second visits to inpatients.

However, what is still up in the air is how many patients a hospitalist can see in a day and still pay second daily visits to some—without having a 16-hour day.

With regard to the “right” daily patient census for hospitalists, Goldsholl said, “We all know that there’s a number after which we are just triaging patients.”

Beyond calculating an appropriate census that enables second visits, there are important safety and quality considerations, she pointed out. “We need more data to show that [seeing] over 20 patients a day is not safe.”

The value of LOS management

A final piece of the puzzle in assessing inpatient rounders versus true hospitalists is examining the dollar value of the two models.

Goldsholl cited approximated figures showing that most professional fee generation factors (charges for a history/physical exam and discharge) between the two types of physicians are equal. One primary difference lies in total revenue per case. On average, she noted that hospitalists generate slightly less money per case, due to a loss in productivity (time spent on the added responsibilities of real-time admitting and second daily visits) and LOS reduction.

However, all other factors being equal, the savings that hospitalists bring through decreased LOS compared with rounders—on average one less day per patient—more than compensates for the difference in professional fee generation. In fact, based on LOS savings alone, Goldsholl estimates that true hospitalists could
save their facility approximately $280,000 per year based on an average of 560 admissions with one additional day of LOS saving per year.

“It certainly puts hospitalists in a position to show that they offer value with regard to LOS savings. In my mind, that means that hospitalists need to be supported. If they are not supported, they can’t take care of patients the way they deserve to be taken care of,” she said.

Hospitalists’ role in improving physician performance

It’s inevitable that your hospitalist program will one day face the fallout from a peer review case in which a hospitalist on the medical staff displayed poor clinical judgment, inadequately followed procedures, or lacked knowledge in a certain area.

Even more common, however, is that hospitalists’ unique position as the hub of the clinical medical staff is increasingly landing them on peer review committees.

According to Robert Marder, MD, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, the issue of peer review is becoming more complex as time goes on. Hospital administrations are demanding ever-higher levels of performance by physicians while placing them under greater scrutiny.

Meanwhile, “physicians are more likely to ‘push back’ as a result,” Marder said during the September 14 HCPro-sponsored audioconference, “Peer Review: Manage, Measure and Monitor Questionable Physician Clinical Performance,” which also featured Todd Sagin, MD, JD, vice president and medical director for The Greeley Company.

Additionally, the healthcare industry’s focus on improving individual physician performance—as well as the general public and government’s interest in high-quality patient care—has forced many facilities to re-evaluate their peer review process. According to Marder, this should include developing or strengthening your strategy for intervention when a problem arises.

To begin, Marder stressed that it is vital to have an intervention process in place even before your hospital is faced with correcting poor physician performance. “If you don’t have a carefully thought-out intervention strategy, the physician who is the subject of concern tends to control the series of events,” he said.

Referencing the “performance pyramid” to show how best to evaluate physician performance (see p. 10), Marder noted another common mistake made by organizations lacking an intervention strategy: They often jump from measuring physician performance against expectations to taking corrective action, skipping over the critical steps of managing poor performance and providing feedback. “This isn’t desirable because it often leads to punitive, stringent action as opposed to collegial intervention,” he said.

The speakers outlined four primary considerations when developing an intervention strategy:

1. Decide whether collegial vs. formal intervention is appropriate.

A collegial intervention is one in which peers work together to achieve better performance, while a formal approach is often characterized by corrective or punitive action and tends to lead to the placement of limitations on a physician’s practice.

Questions? Comments? Ideas?

Contact Managing Editor Maureen Coler

Telephone: 781/639-1872, Ext. 3741  E-mail: mcoler@hcpro.com
When problems are brought to light, Marder said, “good doctors will typically self-correct. However, some are incapable or in need of assistance. In a non-punitive approach, we help our colleagues become stronger, better physicians.” Although the collegial approach is preferred, he said it is often not given adequate due. “When we jump to taking corrective action, all we do is reinforce a punitive culture,” he added.

2. Develop a timeline for intervening. Marder cited patient safety as the most appropriate gauge in deciding the timing for an intervention. “Some [physician interventions] need to take place rapidly, while others can have a more leisurely pace if patients are not directly at risk,” he said.

3. Plan the intervention tactics. A central question that falls under intervention planning is deciding who should carry out the function. Although the intervention is often left up to the department chair, Marder said it’s advisable to consider that he or she may not be best-suited for the task, especially if the chair

- is new to the staff or the chair position
- has little or no training or preparation for dealing with physician performance issues
- has a background in a clinical specialty far removed from that of the physician under scrutiny

In addition, Marder said, “You may need [to involve] a person with a higher level of authority—such as the CEO or a board member—so it’s clear to the physician that the organization takes patient safety very seriously.”

Another factor to consider is location. In this regard, confidentiality should be the number one concern, the speakers said. The initial conversation to inform the physician of the impending intervention steps should not take place in a public area such as a hallway or elevator. Marder recommended finding neutral territory. “Calling a physician into your office is a little like getting called into the principals’ office,” he said. It’s better to stop by the physician’s office and ask when would be a good time to meet.

Last, in planning for action against any physician, it is imperative to understand the hospital’s bylaws. “It’s also a good idea to consult counsel at this point,” Marder said.

4. Prepare for physician pushback. According to Marder, “all doctors will push back at some level” during an intervention. However, keep in mind that the primary purpose is to protect patients. Many people are uncomfortable with interventions, partially because it is not something that is taught in medical school or residency. However, it can help if those charged with intervening begin by reinforcing their role when addressing the physician under scrutiny, Marder added. “Let the physician know you have been asked by the peer review committee to take on this role.”

Finally, the speakers advised practicing the intervention with an appropriate staff member, especially if a difficult confrontation is anticipated. “By practicing how you will respond to pushback, you’ll be better prepared for it,” Marder said.

Editor’s note: If you want to learn more about the audioconference “Peer Review: Manage, Measure and Monitor Questionable Physician Clinical Performance,” go to www.hcmarketplace.com/Prod.cfm?id=3385 or call customer service at 800/650-6787.
better performance of your RRT if you include a physician, and the logical candidates to provide that coverage are hospitalists who are part of an on-site program.”

**Staffing issues**

He stresses that when deciding whether to include hospitalists on the team, the number one consideration should be the staffing model. This is especially true for facilities that want to use the same mix of practitioners on the team around the clock.

However, he adds that hospitals that do not offer 24/7 hospitalist coverage could successfully staff RRTs with an inpatient physician during the day and another practitioner—physician or otherwise—at night.

At academic centers and larger hospitals, medical staff leadership has the added consideration of whether hospitalists who teach medical residents should staff RRTs. Greeno says that fact should not prevent their inclusion on the teams. “If hospitalists are responsible for teaching residents, that instruction should include how to function as part of a RRT. You won’t be leaving your team of residents when you answer a RRT call—you will be taking them with you to teach them that facet of patient care.”

### Compensation

Greeno says there are as many methods to compensate hospitalists for their participation on RRTs as there are hospitals. If the hospitalists are hospital-employed, the RRT work is typically part of their job.

For those who are part of a private practice group, being requested to respond to any sick patient should enable the hospitalist to bill and collect on a fee-for-service basis, according to Greeno.

“Providing 24/7 on-site hospitalist coverage is a more expensive model because you have to pay someone to be in the hospital all the time, but it creates tremendous value for the hospital—much more value than what is spent. Part of that is being available to manage things like RRTs,” he says.

Greeno predicts, “In the future, the majority of hospitals will have RRTs that include hospitalists, and that will become a consumer expectation and the standard of practice.”

**Editor’s note:** For more information about explaining the RRT concept and defining the need within your organization, see Rapid Response Teams: Proven Strategies for Successful Implementation, one of HCPro’s newest books at www.hcmarketplace.com/prod-3650.html.
Pay-for-performance programs debated
Physicians across the United States say programs that use claims data to categorize their performance based on various quality and cost efficiency measures—better known as pay for performance (P4P)—are useful as long as they are fair.

According to a recent HealthLeaders News article (www.healthleaders.com), P4P programs drawing the most fire from physicians

- rank physicians based on cost
- do not disclose to physicians the data on which they are being measured
- use complex formulas to determine the final quality measure or rank

Some P4P models such as BlueCross BlueShield of Michigan’s physician incentive program—which pays physicians rewards based on group size and bases scoring on accessible national guidelines—appear to succeed in that physicians, healthcare services companies, and insurers have agreed on the measurement data. Programs that fail to disclose their criteria up-front to physicians are experiencing roadblocks with regard to physician buy-in.

The CEO of a Shreveport, LA–based cardiovascular group cited in the article the newly implemented P4P program of one regional healthcare company as an example of a program creating frustration among physicians.

During a meeting he described in the article as acrimonious, the CEO learned about the program, which uses claims data to categorize physicians on quality. The article quotes the communications director for the regional healthcare company as stating that its program is not a P4P because it does not reimburse physicians above contractual levels related to performance.

The bottom line appears to be that P4P programs are agreeable to physicians and can help improve healthcare and cut costs—if the programs are considerate to physicians and insurers alike.

Go to www.healthleaders.com/news/print.php?contentid=72244 to access the complete article.