Five years ago, the iPod® existed only in the minds of those at Apple Computer, Inc. In 2003, few people had heard of it. Three years and 42 million unit sales later, iPod is a household name.

“Hospitalists are the iPod of medicine,” says Society for Hospital Medicine (SHM) CEO Lawrence Wellikson, MD, FACP. This is a fitting description for a specialty whose ranks swelled from 2,000 to 15,000 in under a decade and whose docs—most of whom are in their 20s and 30s—fill the gap between outpatient and inpatient medicine for primary care physicians (PCP).

Hospitalist and Practice Solutions Founder and President Kenneth G. Simone, DO, says hospitals use hospitalists to address several areas, but mainly to

- decrease the patient length of stay
- better use hospital resources
- eliminate unnecessary procedures
- improve continuity of patient care

Despite the various uses for hospitalists and the fact that they’ve been around for almost two decades, they are still the new kids on the block. They’re

Mid-level staff, including licensed practical nurses (LPN), RNs, physician assistants (PA), and nurse practitioners (NP), have some of the highest turnover rates in healthcare, according to the 2005 Staff Salary Survey by The Health Care Group. But at the Ogden (UT) Clinic, neither mid-level provider retention nor productivity is a problem; in fact, productivity at the clinic is 30% higher than the national average, says David J. Kane, CPA, MBA, former executive director of the Ogden Clinic and director of business-process improvement for NextGen Healthcare Information Systems, Inc., in Horsham, PA. Kane spoke about this success story during the October 2005 MGMA conference in Nashville, TN.

More than 30 physicians and 25 mid-level providers at Ogden manage a busy caseload, yet the turnover is remarkably low—nearly zero. And despite a nationwide shortage of midlevels, there’s a list of applicants waiting to join this team. What makes this facility so different? An incentive plan that can earn midlevels six-figure salaries and generate additional revenue for physicians, according to Kane. “The insurance companies don’t pay based on seniority, so neither do we,” he said. “Our theory is to pay for performance, and usually more

Malpractice rates are still rising, albeit slower than in previous years. Find out what to expect in 2006.

Point of view: Hospitalists offer benefits to both the hospital and the primary care physician.
also some of the youngest docs out there—the average age of this type of physician is 37, according to the SHM. And as this specialty evolves, so does the role of hospitalists in the hospital.

For the most part, the job entails the general medical care of hospitalized patients, including patient care, teaching, research, and inpatient care leadership. Similar to emergency medicine or critical care, hospital medicine centers on the site of care (i.e., the hospital) rather than on specific organs, diseases, or age groups (e.g., cardiology, oncology, or pediatrics).

However, unlike the emergency department or critical-care units, hospitalists manage patients through the continuum of hospital care. The multiple contact points a hospitalist has with a patient make this specialty so unique and speaks to the history behind its development. Healthcare experts believe the following three events helped shape this specialty:

1. Call changes. The demand for on-call physicians conflicted with limitations imposed by states and the national residency accreditation organizations (i.e., the Accreditation Council for Graduate Medical Education and the American Osteopathic Association) about the number of consecutive hours interns/residents could work. This initiative reduced inpatient coverage by 10%–25% at most facilities, leaving hospitals shorthanded.

2. The shrinking role of PCPs. Over time, PCPs began to recognize that their practices earned more revenue by keeping the doctors in the office rather than at the hospital doing rounds or periodic call.

3. Hospital reassessment of costs due to declining reimbursement. Greater emphasis on decreasing the length of inpatient stays at hospitals, along with the growing number of severe illnesses for hospitalized patients (required to justify admission), made working with hospitals increasingly difficult for office-based physicians.

Hospitalists became the solution to all of these problems: the in-house liaison between the hospital, patient, and office-based physician. They provided the necessary doctors’ numbers for hospitals while addressing their cost concerns. Hospitalists also removed the need for the PCP to visit the hospital, yet still allowed for the patient to receive continuous care and the PCP to receive regular updates about the patient.

Finding strength in numbers

As a young specialty, this discipline has few residency programs, so there are no official statistics about how many hospitalists are in the pipeline. (The SHM is expected to release a report about hospitalists in May.)

However, the SHM reports that 78% of hospitalists come from internal medicine, so the statistics for this discipline may partially apply. The AMA/American Association of Medical Colleges 2004–2005 U.S. Graduate Medical Education Survey shows that there are 21,332 internal medicine physicians, up from 20,914 residents during the previous year. But although internal medicine is traditionally the largest resident discipline, the numbers don’t come close to what the SHM estimates will be necessary to support the demand. Because approximately half of over 5,700 hospitals in the United States currently operate hospitalist programs—consisting of eight to 10 hospitalists—if the other hospitals follow suit as expected, Wellikson says there will be a need for more than 30,000 doctors by 2010.
The limited hospitalist supply means growing recruitment, more leverage to negotiate pay and benefits, and the flexibility to pick and choose where they want to practice and which hours they want to work, says James W. Lord, principal at ECG Management Consultants, a national strategic, operational, and technology-related recruitment firm for healthcare providers. “This emerging specialty is definitely coming into its own.”

But even with the leverage, salaries aren’t increasing. “Overall, their salaries are remaining fairly steady,” Lord says. Last year, ECG tracked hospitalist salaries ranging from $165,000 to $185,000—on par with the current national average for hospitalists (for more about this, see “Hospitalist salary trends 2004–2005” on p. 2).

Lord expects hospitalists’ salaries to continue to rise marginally during the next two to three years before flattening and possibly dipping at the five-year mark. Note that placement results—not precise statistical measures—drive recruiter salary figures.

Mounting turnover in hospital med

Although job opportunities abound, another growing trend is emerging in this specialty: turnover. The average tenure of a hospitalist is four years, says Richard Rohr, MD, director of hospitalist service at Milford (CT) Hospital. Many residents work as hospitalists before deciding to pursue other fields, he says. Others leave because of the stress placed on these physicians.

Hospitalist programs may be getting a handle on the shift assignments by scheduling physicians in blocks of days. Plus, the hospitalists’ offspring—nocturnalists—are helping with schedules. Nocturnalists are hired specifically to work night shifts, thus allowing other hospitalists to work a more routine daily schedule.

“We’re trying to create a specialty [with which] people are satisfied,” Rohr says. “After all, money is one driving factor; but it’s not the only one.”

Recognizing reasons behind slow rising pay

If recruiter numbers often portend salary trends and their numbers pace the national averages of median increases at about 6%–9%, what’s holding the pay steady? Rohr believes salaries are likely to stay fairly stagnant in the coming years because hospital funds drive the pay.

“Hospitals fund hospitalist programs for the added value. In terms of procedure fees, this is a very limited specialty—most hospitalists don’t support themselves on fees,” Rohr says. “Now, if hospitals create financial incentives for greater quality, then that may cause some increases in hospitalist pay.”

Plus, any increases in hospitalists pay come out of general hospital revenues, he adds. And although evidence suggests that hospitalists make hospitals more efficient, it is difficult to place an exact value on the cost savings, which leaves administrators uncertain about how much they should spend on this service.

Also, aside from the limited opportunity for procedure-based revenue, Simone says the lack of patient base diversity plays a role in the pay. “One of the biggest problems hospitals have is justifying their salaries because they work with a majority of Medicare patients and what they bring in on receipts doesn’t typically cover what they do,” he explains.

So hospitals often subsidize hospital medicine programs because the programs save the facility money over the long haul. Hospitalist salaries also seem stagnant because hospitals don’t have much to help them determine what to pay. Because hospital medicine is still new, determining the fair market salary without many sound statistical measures is difficult at best. In most cases, a hospitalist salary is based on what an internal medicine physician would make, but this trend is changing as more information becomes available.

“How do you reimburse the nonreimbursable?” Simone asks. “Now, more than ever, the quality and standard of care are the focus at hospitals—and hospitalists are playing an important part in that.”

PCR sources


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Hospitalists’ pay poses a challenge in the comp puzzle


The number of hospitalists nationwide has nearly tripled to 15,000 since it developed and is projected to double that by 2010, according to the Society for Hospital Medicine (SHM). If your facility joins the ranks of those using these physicians, you must ensure that their compensation is competitive with the market.

When it comes to compensation planning for these physicians, applying the fundamental pay-plan principles is more difficult than with other specialties because the numbers are simply harder to find. Data collection for this specialty happens less frequently than for other specialties, forcing practices and hospitals to use older information for their calculations.

The year 2002 was the last time the SHM conducted its Hospitalist Productivity and Compensation Survey, which polled 300 hospital medicine groups representing approximately 2,000 hospitalists. SHM expects to publish a new survey in 2006. Other salary surveys, such as those from the MGMA, the AMGA, and Sullivan, Cotter and Associates, collect salary information about hospitalists. However, in many instances, the sample size is too small to use them as a benchmark. As pay for these physicians continues to change, these data will become even more important in setting a compensation plan.

“Hospitalists are quickly approaching the level of compensation for emergency medicine physicians, but no one knows where the [salary] ceiling will be,” said Stacy Goldsholl, MD, national medical director for Irvine, CA–based hospitalist company Cogent Healthcare and SHM board member. “With the disproportionate levels of supply and demand, I expect that [the SHM 2006 survey] will show an increase in compensation.”

How regional doctor supply affects market value

Couple the data deficit with naturally occurring regional shifts in physician supply and demand, and the goal of creating competitive salaries for hospitalists based on assessing fair market value is even more difficult.

“In today’s hospitalist market, demand [for physicians] is grossly out of proportion with supply,” said Goldsholl. She pointed to the large number of recruitment ads in hospitalist-targeted publications, as well as increased demand.

Industry experts originally predicted that hospitalist numbers would hit 30,000 by 2010. However, those estimates were based on 2002 data. Robert Wachter, associate chair of the Department of Medicine at the University of California at San Francisco and the first to use the term “hospitalist,” and a growing number of other leaders in the field now estimate that there will be roughly 30,000 hospitalists by 2010.

“There are roughly five jobs for every practicing hospitalist in the United States today, clearly making it a buyer’s market,” Goldsholl said.

Create a two-facet salary structure

Goldsholl recommends offering a compensation package with both a fixed and a variable component. “This means offering a base salary that will attract the best hospitalists, but also offer a variable or bonus portion to motivate the hospitalist to perform at the level you expect and the level the client [e.g., hospital, multispecialty group, referring physician, etc.] expects.”

Another consideration with regard to salary packages is the age of hospitalists, Goldsholl said. Generation X and Generation Y physicians (those born after 1965) are not as willing to work in a productivity-only compensation system, she said. They view it as too risky.

Lastly, don’t make your compensation plan complex. Start by identifying your organization’s specific needs, which likely will vary depending on the hospitalist’s employer (e.g., hospital, private group, or large academic medical center). Once you outline your organizational goals, you can then identify the areas for which to reward well-performing hospitalists.

PCR source

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Incentive plans

years of experience results in the ability to be more productive.”

Other facilities are also seeing the positive effects of mid-level provider incentive plans. Catholic Health Initiatives (CHI) in Des Moines, IA, manages 1,200 providers in 19 states, 200 of whom are mid-level staff. To maintain high productivity, CHI uses multiple mid-level provider incentive plans, explains CHI Director of Medical Affairs and Practice Management Theresa Lewis, CHE.

“We find that [monetary] incentives provide a very real motivation to increase productivity,” she says. Because duties vary depending on the type of mid-level, practices should consider not only the mid-level’s responsibilities/skill level, but also the group’s overall goals. This may mean creating several incentive plans for each type of mid-level provider, which will add extra work at the onset. This is how CHI addressed incentivizing midlevels at their facility.

“At the end of the day, we find [that] these plans increase the revenue flow at the practice, and the patients also report being more satisfied—so everyone benefits,” Lewis says. “Plus, I think giving the midlevels recognition for their contributions is very important, and this does that.”

Put productivity back to work for you

There are a broad range of productivity levels within mid-level posts (e.g., a seasoned midwife may be more productive than one just starting out), which can directly affect your bottom line, said Cary B. Edgar, Esq., principal at Ancillary Care Solutions, LLC, in Scottsdale, AZ, and Kane’s cospeaker during the MGMA conference. “It’s important to attract and retain the most productive mid-level providers. If you pay all of them the same $70,000 a year, they’ll likely do fine, but they’re not going to go the extra mile—and that’s what you really want,” he said.

To create an incentive program, look at each mid-level provider’s current productivity (which may include gross charges, number of patient encounters, etc.)—that’s the base. Then factor in the goals your practice would like to achieve (e.g., better documentation, coding, increased productivity, etc.). Once you have the basic information, think about what might provide the most incentive to these staff.

For example, you might offer to pay them an additional 15% of any amount they collect that’s more than their original base. Suppose that an average PA generates a base productivity measure of $250,000 annually. During the next year, with the incentive plan in place, he or she generates $275,000 (or $25,000 more than without the plan). So the PA would get an additional 15% of the $25,000, or a $3,750 incentive bonus on top of the base salary.

“Adding an incentive like this costs a practice nothing because it generates even more revenue overall,” Edgar said. “You’re simply paying the mid-level a percentage of the growth. Plus the midlevels don’t have to worry about losing any money because it doesn’t affect their base [pay].”

Create a practical program

Just as a physician incentive plan derives from any number of elements (e.g., productivity, gross charges, documentation, patient satisfaction, etc.), so can an incentive plan for mid-level providers. However, when adding this type of program to your practice, Edgar recommended that you:

- create reasonable targets for productivity levels or other targeted measures
- select a percentage that’s reasonable for the practice but motivational to the midlevels
- factor in demand for mid-level providers in the immediate area
- consider the practice’s overall goals and create a plan that complements them
- make the incentive plan as simple as possible
- keep ancillary services out of the incentive plan
- be flexible and expect to adjust the plan as circumstances change
- ensure that the plan ties to giving patients appropriate care

As with physician incentive plans, if the mid-level provider plan is not linked to quality patient outcomes, the number of patients seen or the type of services provided may increase, but the level of patient satisfaction may decline. To prevent...
Incentive plans

this, add a component to the plan that accounts for patient satisfaction.

Although midlevels are likely to be enthusiastic about the addition of an incentive plan, physicians at the practice may be uneasy about it. So before adding any plan, Edgar recommended presenting the program to your doctors. Explain why the practice should consider a mid-level provider incentive plan and ask for feedback from the physicians.

"If the majority of doctors aren’t on board, don’t implement the plan—it will cause resentment," he said. "But try to use numbers to show them how this plan helps them earn more money and ask for a six-month trial period. Once it’s added, most practices see the [financial and productivity] benefits almost immediately."

Encourage retention

As part of the presentation to your providers, remember to factor in the cost of staff recruitment versus staff retention. It costs more to recruit a mid-level provider than retain one, and regional mid-level shortages give these providers more wiggle room.

“These days, students can go where they like. They have the leverage to negotiate,” says Sandra Tunajek, CRNA, MSN, DNP, director of practice for the American Association of Nurse Anesthetists in Park Ridge, IL. Tunajek suggests that practices that undertake recruitment provide midlevels with more than a competitive base salary. “Candidates review pension plans, the 401k, health benefits, and incentive/bonus plan opportunities before they take a position these days because they know their skills are in demand,” she says.

Prevent losing qualified midlevels by using both large and small incentive plans, says Shelley Cohen, RN, BS, CEN, educator and consultant for Health Resources Unlimited in Hohenwald, TN. To monetarily satisfy staff over longer periods, use incentive compensation plans. However, small gestures (e.g., gift cards and letters of praise) work well for short-term employee satisfaction.

“You could spend thousands to recruit a new staff member or you can show your appreciation with a $150 gift card and retain that person for another six months,” she says. “Plus, the happier your staff are, the happier your patients will be.”

PCR sources

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Encourage desired physician behavior; improve productivity through performance measures

Before you can develop a pay plan that rewards physicians for their productivity, you must first determine the best way to measure performance. However, rather than just figuring out which behaviors to measure and how to gauge them, also consider which activities the physicians (or practice) need to change, says Kenneth Hekman, FACMPE, president of The Hekman Group, a business management planning and development strategy company for physician practices.

How the practice measures physician productivity can send a message about the traits and actions you value and affect how your physicians perform. For example, a physician seeking to boost his or her perceived value may perform differently when rated on revenue, patient contact, or other performance measures.

Recognize the five core performance measures

When developing your compensation plan, consider the following five traditionally popular performance measures, keeping in mind the message that each one sends to your physicians:

1. Gross charges. In the past, practices commonly used gross charges to discern variances between physicians in a group, in part because the group could measure them easily and affordably. This appealed to small groups without the resources or infrastructure to track more complex measures, Hekman says.

   But relying solely on gross charges can be misleading, says Margie Andreae, MD, associate professor and associate director for the clinical services division of general pediatrics at the University of Michigan Health System. Fee variations between communities could reveal apparent but inaccurate differences in gross charges of physicians.

   For example, a physical exam may cost $80 in one community and $150 in another. Measuring performance with gross charges allows a physician in the higher-fee area to receive a better performance rating than a physician who performs the same exam in a low-fee area.

   Incentives: Gross charges comprise any service with an associated fee, including ancillary tests. Measuring performance with gross charges sends the message that money is the top priority at the practice; the prospect of a higher income may lead some physicians to order unnecessary tests or procedures, Andreae says.

2. Collections. The collections performance measure is similar to gross charges, but takes into account revenue from a service generated during the billing and collections process, not just the initial charge. Because measuring performance should ultimately divide the comp pie, many practices prefer a measure that looks at revenue, says Andreae.

   But this method can also pose problems. Like gross charges, collections are not standardized nationally or even between neighborhoods. "If you have a group with one office in an underinsured area and one office in an area where everyone has coverage, you will find [that] your collections will vary, but the physicians may be doing the same amount of work," Andreae says.

   Incentives: Measuring physician performance with collections provides a similar incentive to gross charges and may tempt physicians to boost their performance with unnecessary tests and spend an excessive amount of time and energy focusing on contracts and reimbursement.

3. Patient visits. Because it fails to take into account variations between cases, using patient visits as a performance measure only works for specialists who perform a similar function with each patient, Hekman says. Similar to gross charges and collections, patient visits are easy to measure, but because a simple exam has the same weight as a complex procedure, patient visits don’t accurately reflect the varying complexities of each task a physician performs.

   Patient visits often reveal more about cost allocation than physician performance, Hekman says.

   Incentives: Measuring your physicians based solely on patient visits may encourage them to focus on simple, quick cases, a process referred to as churning, Andreae says. "You may then incur higher referral rates," she says. "Doctors are more likely..."
Performance measures

< p. 7

to send a patient to a specialist because they won’t be willing to spend the time on the more complex cases.”

4. Patient contact hours. Some practices measure physicians based on the number of scheduled hours they spend with patients each day. Although this will give you an idea of the amount of time for which your physicians work, you still won’t know whether they use their time efficiently.

Set goals that reward physicians who work a certain number of hours, but manage the schedules carefully to ensure that physicians spend this time with patients and not performing administrative tasks around the office.

Incentives. Similar to patient visits, patient contact hours do not tie in to revenue. Hypothetically, a physician who undercodes a visit or offers free treatment to relatives would receive the same performance rating as the top revenue-generating physician in the group, as long as the two work the same number of hours, Andreae says.

5. Relative value units (RVU). When Medicare adopted RVUs as its productivity standard, many in the healthcare industry followed suit. Work RVUs are designed by Medicare based on the work performed by a physician specific to a particular CPT code. Unlike the previously mentioned performance measures, RVUs take into account variations in each procedure a physician performs.

“The clearest benefit of an RVU is that it creates a common language for all specialties and clearly defines the amount of work that goes into each service,” says Hekman. “Physicians don’t have to argue within the group what an RVU should be worth. It’s already laid out by the federal government.”

Incentives. RVUs encourage physicians to treat each patient and case equally by measuring individual services relatively. However, RVUs are not tied to revenue and can vary depending on payer, Hekman says. “You might earn $60–$70 per RVU from some payers and only $30–$40 per RVU from a government program. You still have to look at what an RVU is worth at each practice given the payer mix and the negotiating climate with individual payers.”

Customize your performance measure

There are as many ways to measure performance as there are practices, which means that you don’t have to rely on one of the traditional methods, says Hekman. Some practices use qualitative measures such as patient satisfaction surveys to evaluate and reward their physicians, although the results can be unreliable and biased, Andreae says.

Other practices and consultants modify traditional performance measures to better fit their needs. For example, time units (TU) are similar to RVUs but more appropriately reflect the complexity of the CPT codes, says Ronald Riner, MD, who spoke about TUs during the February HCPro, Inc., audioconference “Implementing time units in lieu of relative value units.” TUs measure productivity using a physician-agreed-upon allocation of time for each encounter or action. However, unlike the nationally standardized RVUs, practices must develop TU standards internally, which can take time.

Mix and match measures to meet your goals

Before attempting to choose a performance measure, articulate your compensation goals, Andreae says. “The performance measure you pick needs to align with your overall goals. For example, if you’re trying to improve access, you might want to focus on visit numbers or patient contact hours in the clinic.”

After you know what goals you want to achieve, don’t limit yourself to one type of measure. You can overcome many of the flaws inherent in each individual performance measure by combining the various measures to meet the goals.

One caution: Don’t combine more than two or three measures or you risk sending physicians mixed messages about their performance, Hekman warns.

PCR sources

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Advocates and proponents of malpractice insurance tort reform go toe-to-toe over survey’s results

Controversy over medical malpractice tort reform has been stirring for years, with proponents and advocates issuing reports that argue their points. These survey results are often key to proving legislation should pass—and there’s plenty of legislation to consider.

In 2005, approximately 430 bills addressed various aspects of malpractice nationwide, covering everything from attorney fees, damage limits, and doctor apologies to insurance funds, reform, and reporting.

Cut to the controversy

The myriad legislative activity on medical liability often spurs debate, proven once again by the controversy over the recent study False accounting: How medical malpractice insurance companies inflate losses to justify sudden surges in rates and tort reform by the Foundation for Taxpayer & Consumer Rights (FTCR). Released in December 2005, the study has intensified debate about the liability insurance crisis by claiming that insurers grossly overinflated estimated losses to justify rate hikes.

The FTCR reports that during a nine-year period, insurance companies overstated initial incurred (or estimated) paid losses. From 1986 to 1994, the industry reported losses of $39.6 billion, but actually paid out in claims only $26.7 billion.

“The essence of malpractice is that they estimate numbers, but what we see here is that there’s something fundamentally wrong with the numbers or formulas they are using to derive their estimates,” says Carmen Balber, FTCR consumer advocate.

Because malpractice cases can take up to five years or longer to clear the court system, the FTCR examined data a decade back. “There’s no way to measure the accuracy of incurred loss reports until a period of time has passed; we used 10 years,” explains Balber. “Claims from 2001 simply haven’t been around long enough to judge whether incurred loss reports were inflated or not.”

She says the FTCR doesn’t expect insurers to make exact estimates, but consistently high estimates indicate a problem (see the table below). “The malpractice insurance industry claims they have skyrocketing payouts, which cause these ridiculous premiums for doctors, but the numbers don’t hold true. How they arrive at these premiums needs to be reassessed,” she says.

Other organizations, however, such as the Physician Insurers Association of America (PIAA) and AMA, say the FTCR report is misleading and used a flawed methodology. “The report cherry-picked the years studied,” says Lawrence Smarr, president of the PIAA, a trade association comprising more than 60 professional liability (medical malpractice) insurance companies. “It’s clearly aimed at derailing state tort reform.”

Addressing the increasing premiums, Smarr notes that more than 50% of the insurance sold is by companies owned and operated by providers who joined together, and it doesn’t “make sense that they would collude to overcharge themselves.”

Premiums are not overinflated, he says,

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Note: This table shows claims-made coverage and represents only four of the nine years of data the FTCR discusses in its report.

pointing to data in Best’s Aggregates & Averages—United States & Canada, a series of books of current and historical statistics about the insurance industry. According to Aggregate figures, insurers actually pay out more than they take in (see the table above).

**Put a cork on caps**

Payouts are just one area that the FTCR report reviews; it also examined liability caps. The FTCR survey summary says states with liability caps on noneconomic damages paid less than insurers in states without caps. The report concludes, “The insurance industry is in need of stringent regulatory and accounting reform” and until that transpires, a moratorium is necessary on both rate increases and legislatively enacted limits on legal rights (i.e., tort reform).

Smarr says the FTCR report is just another tool for those who oppose tort reform. “It’s misinformation that adds to the stalemate, but it doesn’t add anything useful to the debate,” he says.

“In this industry, the books need to be open to determine whether insurance companies are charging fair rates,” Balber says.

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**Still on the upswing: Malpractice rates likely to continue moderate climb**

Malpractice insurance accounts for a considerable portion of any physician compensation plan, and depending on the specialty, it can be the largest fixed expense for a practice. For more than 15 years, physicians have struggled to get atop this expense while watching their reimbursements decline. Unfortunately, it appears that premiums will continue to rise, forcing physicians to forge on with this battle.

The Chicago-based newsletter Medical Liability Monitor publishes an annual report, one of the few on medical malpractice insurance rates, which tracks nationwide malpractice rates for internal medicine, general surgery, and obstetrics/gynecology (OB/GYN). In October 2005, the newsletter released its 15th annual rate survey showing that although premiums increased in 2005, “the increases were generally lower than in recent years.”

The survey reports most of the rate changes as being in the 0–14.8% range. In previous years, changes were between 6.9% and 24.9%. The newsletter expects rate changes for 2006 to continue to be moderate.

Florida, Illinois, Michigan, Ohio, and Pennsylvania saw the highest malpractice rates for the three specialties. (Note: For OB/GYNs, Connecticut was named to the list and Michigan was dropped.) Minnesota, Nebraska, South Dakota, Idaho, and Wisconsin recorded the lowest premiums.
Outpatient medicine has become increasingly complex. Advances in medical technology have made it possible for outpatient settings—often physicians’ offices—to offer more and more services.

A residual effect of this is the changing face of inpatient medicine. Fewer patients are hospitalized today, and those who are often have multiple comorbidities. For many primary care physicians (PCP), the above factors, coupled with declining reimbursement, have caused them to reexamine how they structure their practices, where to prioritize their time and resources, and how to best care for their patient populations. For an increasing number of PCPs, hospitalists address these issues.

PCR asked Mary Jo Gorman, MD, MBA, member of the American College of Physician Executives, chief medical officer of IPC–The Hospitalist Company, and president-elect of the Society of Hospital Medicine (SHM), to explain how hospitalists affect primary care medicine and healthcare.

What is the function of a hospitalist?

Hospitalists work with and for the PCP and focus exclusively on hospital medicine. Hospitalists have been shown to increase quality, reduce costs, shorten lengths of stays, and lessen readmit rates while increasing patient satisfaction.

Thanks to the support of PCPs around the country, coupled with the quantifiable evidence of the value of hospitalists, these physicians have become the nation’s fastest-growing medical specialty. Estimates are that there are more than 15,000 hospitalists practicing today with that number expected to rise to 30,000 by the end of the decade.

The hospitalist presence and singular focus on hospital medicine drives the delivery system toward better overall care. PCPs who refer their patients to hospitalists also benefit by refining their outpatient skills, adding efficiencies to their office practice, focusing their attention where their passions lie, and recognizing an improved and quality of life.

Why do physicians opt to specialize in this area?

Many physicians, particularly newer residents, find that they have a proclivity for outpatient care, whereas others have one for the acutely ill. The emergence of hospitalists allows physicians to focus where their passions lead them.

Plus, because hospitalists concentrate 100% of their time in the hospital, they have even greater proficiency with inpatient work. This allows PCPs to concentrate on the skills needed for outpatient services. Given that outpatient care is more comprehensive than ever, both PCPs and their patients benefit from the additional time and energy they can devote to keeping abreast of advances that unfold in outpatient care.

How does using a hospitalist’s services affect PCPs’ compensation?

Through increased efficiency, PCPs can increase productivity, generate more revenue for their practices, and ultimately boost their compensation. The average PCP has one or two hospitalized patients per week today versus 10–12 patients per week 20 years ago. It’s no longer practical for PCPs to go to their local hospitals once or twice per day to see a diminishing number of hospitalized patients.

Staying in the office means fewer canceled or delayed appointments and ultimately greater productivity for the PCPs.

Does using a hospitalist affect acute-care patient treatment?

One of the best advantages of hospitalists is that they’re more familiar with hospital processes than outpatient physicians who may visit the hospital infrequently. The typical PCP doesn’t usually see more than three times per year any one condition requiring hospitalization, according to a Washington, DC, Healthcare Advisory
Board study. But hospitalists spend 100% of their time in hospitals and focus on acute conditions, so they see certain illness more frequently than the average PCP.

Working at the hospital also gives these physicians insight on expediting care within that environment (e.g., a hospitalist can act on test results immediately and adjust the patient’s treatment accordingly). Plus, hospitalists know most key hospital personnel (e.g., medical and surgical consultants, discharge planners, clergy, etc.) and can facilitate connections with postacute providers (e.g., home health aides, skilled nursing, etc.)

**PCPs did not embrace hospitalists at the onset. What changed?**

Studies show that as a group, PCPs no longer question the quality or continuity of care hospitalists can provide. PCPs have come to view hospitalists not as “internists without offices,” but as specialists in inpatient medicine.

PCPs also started to recognize that hospitalists actually provide great value by improving continuity of care, communicating pertinent patient information to staff at shift changes, and coordinating as many as 50–100 people involved in a patient’s care.

Also, PCPs realized that hospitalists are partners, not competitors, and that they won’t steal their patients. In most instances, hospitalists dedicate 100% of their time to inpatient medicine—in a recent SHM survey, more than 85% of hospitalists reported no outpatient practice at all.

In addition, as hospitalist programs start up at even more hospitals, the PCPs’ work-life balance will improve exponentially, reducing or eliminating the need for PCPs to participate in on-call duties. Hospitalists provide facilities with 24/7 coverage, code-blue coverage (or emergency assistance), manage patients on weekends, and offer vacation support—which PCPs can utilize as much or as little as they wish.

Editor’s note: Gorman is a member of the American College of Physician Executives, chief medical officer of IPC-The Hospitalist Company, and president-elect of the SHM. Visit [www.hospitalist.com](http://www.hospitalist.com) for more information.