Case managers: Not just for discharge planning

Case managers guide patients through their entire hospitalization—not just discharge. Does your program fully utilize these gems? Learn more on p. 7.

Educating referring MDs key to offering palliative care

Read how hospitalist programs that successfully provide palliative care services make it a priority to educate referring physicians about the program on p. 9.

Ask the expert

More surgical specialists seek consult-only roles. Our expert answers a reader’s question about how global surgical fees work on p. 10.

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Early malpractice cases show potential danger zones for specialty

Unlike other specialties, hospital medicine has not existed long enough to have a significant history of malpractice claims. Hospitalists do not have thousands of closed claims to help identify the danger zones in their field or underscore the types of conditions, procedures, and patients that are most likely to land them in court.

However, there are early caution signs hospitalists should be aware of in order to mitigate malpractice risk, says Eric Siegal, MD, codirector of the hospital medicine program at the University of Wisconsin in Madison.

 Contributing to the lack of information, many insurers do not yet use unique identifiers for hospitalists, but rather identify them by their original specialty, which is generally internal medicine, Siegal says. “There is a paucity of information [about hospitalists and malpractice]. When you look at insurance data, there is no way to differentiate hospitalists. We’re at risk for failure to diagnose, failure to communicate, failure to refer, > p. 2

Locum tenens: Make it a permanent contingency expense

The reality for many hospital medicine programs is that there simply aren’t enough hospitalist candidates to fill the demand. Add surging patient demand and resident duty-hours limitations, and it’s no surprising that the use of locum tenens—or temporary physicians—by hospitalist programs is growing rapidly.

The use of locum tenens, a Latin term meaning “to stand in the place of,” began 20 years ago with a government grant aimed at offsetting severe physician shortages in rural areas. As physician shortages spread through every specialty and region, the industry flourished. As of 2004, spending on temporary physician services approached $3 billion nationwide, according to Irving, TX–based Staff Care, Inc. (www.staffcare.com), a temporary physician-staffing firm. Staff Care released the report, Growing Number of Physicians Working as Temps in 2005.

Overview of locum tenens

Once an offshoot of medicine that many physicians considered a less-than-desirable alternative to a permanent hire, attitudes toward temporary physicians are rapidly changing. Consider that in... > p. 5
Malpractice cases

On one hand, Siegal says this “mission creep” may be gratifying and make hospitalists feel that they are rewarded with opportunities to be involved in certain aspects of patient care that other specialists do not have. However, it can also lead hospitalists into dangerous territory.

“We are asked to do [things] we may not necessarily be qualified to do,” he says, noting that hospitalists often do not have board certification in certain specialty or subspecialty areas in which they may be asked to practice. “I have been asked to do stuff at 3 a.m. that no one would ask me to do at 10 a.m.”

Hospitalist program directors may also be faced with a situation in which some hospitalists are comfortable covering for intensivists, for example, while others are not. “You’re only as strong as your weakest link,” says Siegal. He advises practices that have hospitalists with varying comfort levels to adopt an across-the-board policy, stating that they will or will not cover for intensivists, for example. Alternatively, the hospitalist service could create safeguards (e.g., unique schedules, teams, etc.) so the hospitalists who do not feel comfortable covering for intensivists are never placed in that situation.

To resolve a similar dilemma, hospitalists and cardiologists at the University of Wisconsin jointly developed a set of admissions criteria. Under the criteria, a cardiologist must serve as the primary attending physician for patients with ST-elevation myocardial infarction or cardiogenic shock, while the hospitalists take primary responsibility for patients with unstable angina, or less severe heart failure.

2. Comanagement of patients. Another potential trouble area regarding malpractice risk results from hospitalists’ role in comanaging patients with surgeons and subspecialists. Specifically, areas of responsibility can become blurred, and disagree-
ments may erupt between providers about how to manage a patient.

For example, orthopedic surgeons and hospitalists may disagree about how aggressively to prevent blood clots. Hospitalists generally worry more about the consequences of a blood clot, whereas surgeons tend to worry more about the consequences of bleeding, so each may be biased in terms of how aggressive the prophylaxis should be, Siegal says.

“There are legitimate differences of opinion about how to manage problems,” he adds. As much as possible, hospitalists and other specialists who comanage patients should clarify and negotiate their areas of responsibility in advance and work out their areas of disagreement, Siegal advises.

For example, a surgeon and a hospitalist could agree to consult with one another before either of them treats a postoperative infection. Further, it is incumbent on the hospitalist to ensure that these discussions are conducted in a diplomatic and collegial manner because the hospitalist depends on the specialist for future referrals, he says.

3. Overcommitting. “Hospitalists are the new kid on the block,” Siegal says. Not only are they eager to build their new practices, “but everyone wants to use their services.” There are few guidelines about appropriate workloads for hospitalists and unrealistic expectations about how much they can accomplish abound, making it easy for hospitalists to overcommit. And some benchmarks for how many patients a hospitalist can manage daily are far too high to ensure safe, quality patient care, Siegal says.

As a result, Siegal advises that hospitalists create “pop-off valves” that close services when they become overextended, he says. The threshold should not be a hard-and-fast rule based on volume only, but should take into account the acuity of the patients and be somewhat flexible. At Meriter Hospital, a University of Wisconsin community affiliate, the threshold is about 20 patient encounters per day, Siegal says. But it is used primarily as a

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, 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. It appears that premiums will continue to rise, forcing physicians to forge on with this battle.

According to the Society of Hospital Medicine, most hospitalists are covered by institutional or group employers because they are hired directly by a hospital or an agency that contracts with the hospital.

The Chicago-based newsletter Medical Liability Monitor publishes an annual report (one of the few about medical malpractice insurance rates) that 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 the majority of the rate changes 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 newsletter’s list and Michigan was dropped.) Minnesota, Nebraska, South Dakota, Idaho, and Wisconsin recorded the lowest premiums.

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guide. If a hospitalist is caring for 17 patients, with four in the intensive care unit, he or she may decide to divert patients to internists, family practitioners, or specialists, he says. If all 20 patients are stable, he or she may decide to accept another patient that day.

Before taking his post at the University of Wisconsin, Siegal founded Inpatient Services, PC, a Denver-based hospitalist practice. In that practice, physicians were instructed to call for help when their patient census exceeded a predetermined safety threshold. Siegal and his fellow hospitalists developed a “jeopardy system” in which physicians were scheduled to be on call during their days off in case the patient threshold was exceeded. When taking a jeopardy call, a hospitalist had to be available by pager or cell phone and be able to report for duty within 90 minutes of being called. “We came up with the 90-minute rule by gauging the average return trip from the major ski resorts,” jokes Siegal.

**Communication**

Miscommunication with patients is hardly a problem unique to hospitalists. In fact, it is one of the most common causes for malpractice actions. However, hospitalists’ unique role of caring only for patients in the hospital—without the benefit of an established relationship—may create special vulnerabilities, according to Siegal.

“Hospital medicine is built on the notion of discontinuity,” Siegal says. Hospitalists treat new patients during a hospital stay, which is “a short period that is inherently disconnected from the rest of their healthcare experience,” he says. “This is a huge area of vulnerability if we don’t handle it well.” As a result, hospitalists have only “three or four days to establish a trusting, therapeutic relationship under extreme pressure.”

Although the duration of patient care is short, Siegal notes that a hospitalist is often more available to the patient in the hospital than the referring physician or specialist and may be more likely to meet family members. This advantage may balance out some of the other communication risks hospitalists face. “Some data show that dissatisfaction with discontinuity of care is offset by a lot more hands-on attention,” he adds. Communication with other providers is also fraught with potential pitfalls for the hospitalist.

As such, it is important for the hospitalist service to set up mechanisms that create expectations for information that is communicated regularly, Siegal says.

Hospitalists also need to be excellent communicators. “In residency, no one teaches you to communicate,” Siegal says, adding that house staff have a tendency to dictate discharge summaries that read like a “magnum opus.” Information needs to be transmitted quickly and efficiently so key points are made and not lost along the way. Siegal points to Robert Wachter, MD, professor of medicine at the University of California, San Francisco Medical Center and a pioneer in hospital medicine, who says that every time information is conveyed from one person to another, there is the potential for a “voltage drop”—the loss of a certain amount of information or the loss of a nuance in information.

According to Siegal, being vigilant about risks in these problem areas of hospital medicine practice not only will help protect hospitalists from lawsuits, but will also result in better and safer patient care. “Good risk management is better patient care,” he says.
Locum tenens

2001, an estimated 27,000 physicians worked in locum tenens positions, and just three years later, that number skyrocketed to 34,000, according to the Staff Care survey.

In addition, the locum tenens demographic defies what many in healthcare might expect. Instead of the ranks of locum tenens being ripe with new physicians trying to gain experience, 85% had more than 10 years of experience, and of those physicians, 33% had more than 31 years of experience, according to a 2002 Profile of a Locum Tenens Physician report produced by CompHealth (www.comphealth.com), a nationwide provider of recruiter and healthcare staffing services.

“There used to be a stigma about locum tenens that they are the physicians who can’t get permanent jobs or that they are all retired physicians who want to dabble in medicine,” says Sherri Carlton, CTS-PRC, director of Delta Locum Tenens (www.deltalocums.com), a national locum tenens firm also based in Irving, TX. “It’s just not the case.”

Why are so many seasoned hospitalists now on board? Industry experts say it’s because locum tenens positions enable hospitalists to create flexible schedules and practice medicine without the burden of administrative responsibilities—the latter of which often becomes part of hospitalists’ job descriptions.

Results from the CompHealth report show that locum tenens physicians were “significantly less affected by the factors that contribute to discontent among physicians practicing medicine on a permanent full-time basis.” In fact, physicians who participate in locum tenens programs show a high level of satisfaction in these posts, in part because they did not have to deal with

- malpractice insurance (81%)
- Medicare/Medicaid reimbursement (76%)
- administrative responsibilities (63%)
- managed-care issues (42%)

Temporary physicians are not the only ones satisfied with using locum tenens to fill these vacancies—the Staff Care survey shows that practices and facilities are also pleased with locum tenens arrangements. Nearly 56% reported that the work of locum tenens physicians was equal to or superior to existing staff, and 39% reported that they were average compared to existing staff.

Only 5% of locum tenens had their performance considered as being below average by the temporary employer.

Meet the need for stopgap hospitalists

With high levels of satisfaction by both employees and employers, locum tenens numbers continue to grow. “This is a multibillion-dollar industry, and there is not just one type of facility that uses locum tenens,” Carlton says. “We place [physicians] anywhere there is a need.”

Despite this widespread demand for physicians, the need for temps most often occurs in eight specialties: anesthesiology (including certified nurse anesthetists), psychiatry, radiology, orthopedic surgery, general surgery, family practice, general internal medicine, and pediatrics. (Many locum tenens placement firms still count hospitalists within the internal medicine subset and do not yet break out hospitalists into their own category.)

“Specialties such as radiology, anesthesiology, and emergency medicine utilize locum tenens frequently due to the nature of shift work and hospital contracts,” says David Baldridge, vice president of the locum tenens division at CompHealth. “Still, we’re seeing increased demand in all settings—job orders are up in both group practice settings and hospital settings.”

—David Baldridge

“A facility or practice should use a locum tenens physician when there is a defined gap in its staffing—that includes the time it takes to recruit a permanent physician if it has an opening.”
The industry is booming because of large physician shortages and practices’ need to meet the demand and maintain the quality of care, Carlton says. The Staff Care survey shows similar results—practice and facility respondents say they most often use locum tenens to maintain continuity of care (76%), to prevent loss of revenue from understaffing (44%), because of the immediate availability of the physicians (44%), and to prevent burnout of staff docs (27%).

Address shortages without short-changing

Although many hospitals first think of recruiting a permanent physician to meet a staff shortage, the process can take four to six months to complete.

“A facility or practice should use a locum tenens physician when there is a defined gap in its staffing—that includes the time it takes to recruit a permanent physician if it has an opening,” Baldridge says. Plus, interim coverage with a temporary physician can prevent revenue loss, Carlton adds.

Locum tenens physicians are also useful in settings in which the patient census fluctuates seasonally. If a hospital needs six physicians four months out of the year and only five physicians to meet patient demand the remainder of time (e.g., a hospital in Florida that sees an influx of “snowbirds” during the winter months), supplementing one locum tenens physician is a better option than maintaining a year-round staffer for a peak season, says Baldridge.

Rural hospitals might also use locum tenens as a safety net, says healthcare consultant Jon-David Deeson of Knoxville, TN–based Pershing Yoakley & Associates, PC (www.pyapc.com). “Our physician clients situated in less desirable locations have real difficulties recruiting permanent physicians,” he says.

Tailor the plan for your specific needs

Regardless of whether the need for additional physicians is predictable (e.g., regional shortages) or unpredictable (e.g., a resignation or leave of absence), hospitals benefit from putting a locum tenens contingency into the compensation plan budget. You can’t always anticipate when a hospitalist shortage will arise, but failing to plan for one can disrupt your facility’s revenue and overall performance.

Just as a compensation committee allocates funds for a new physician hire, allocate funds for a locum tenens line item—usually part of the overhead portion of the plan—in case of a staff shortage.

“Many practices have locum budgets or put an item in their recruiting budget,” Carlton says.

To determine how much to apportion for a locum tenens physician, perform a cost-benefit analysis, says Baldridge. Assess whether you require a permanent physician or a locum tenens—and remember, the situation may not be clear-cut.

Review the actual cost to hire a permanent physician versus a locum tenens and calculate benefits, relocation costs, bonuses, malpractice and tail coverage, placement-agency fees, and any other expenses.

Weigh these expenses against the reason for the new hire (e.g., to fill in for another hospitalist’s leave of absence) and the potential benefits of a new hire (e.g., increased revenue, additional patients, expansion of ancillary services, etc.).

Although locum tenens hospitalists can be expensive, in some cases, they are the less expensive option. Carlton says practices must realize that placement agencies pick up many of the costs (e.g., liability insurance) for a locum tenens hospitalist that the hospital would normally absorb when hiring a full-time physician.

“The physician supply does not look to be catching up with demand anytime soon,” Baldridge says. “In addition, more and more physicians are pursuing locum tenens as a career option, citing quality-of-life issues and flexibility.”
Case managers: Not just for discharge planning

From admission onward, they keep hospitalists on track with care plans

Hospitalists shortchange themselves and their institutions if they rely on case managers for discharge planning alone, says Stefani Daniels, RN, MSNA, CMAC, managing partner of Phoenix Medical Management, Inc. (http://phoenixmed.net).

“Nine out of 10 hospitalists will tell you there’s a wonderful advantage in working with a case manager on discharge planning,” says Daniels. “But to take full advantage of case managers’ talents and expertise, hospitalists need to rely on [them] for so much more.”

Their adeptness at guiding patients through their entire hospitalization is much greater than most hospitalists realize, she says.

Daniels, who provides training and consulting services to hospitals’ case management programs, says case managers can help hospitalists stay on track with the most appropriate care for patients and be allies in providing cost-effective and quality care. A case manager can be a resource in all three phases of a patient’s episode of care, including

- access or admission
- treatment or throughput
- transition or discharge

“There’s a commonality of goal,” Daniels says. “Like the hospitalist, the case manager wants the best care in a swift and timely manner.”

Case manager as gatekeeper

A case manager coordinates the goals of the clinical team with those of the patient and family and helps achieve quality outcomes while managing the financial realities of payers and families.

At admission, the case manager will ask questions about whether the hospital will provide the most appropriate level of care, Daniel says.

“Hospitals are a high-risk venue, especially for a frail patient,” she says, referring to the risk of medical errors and infection from a hospital stay. A good case manager will encourage the hospitalist to consider whether there is a more appropriate level of care than the hospital, depending on the circumstances of the patient and family.

At Danbury (CT) Hospital, Matthew Miller, MD, chief medical officer, says case managers assigned to the emergency department (ED) “play a critical role in determining the appropriateness of an admission.” If a family brings an elderly relative to the ED in desperation and the patient is fine, the case manager can quickly arrange for more appropriate placement, such as home care. The case manager can head off at the pass an inappropriate hospitalization that may not be reimbursed.

The case manager is an expert on reimbursement policies who has a fiduciary responsibility to assess whether the admission is justified under the policies of Medicare, Medicaid, or the patient’s health plan, adds Miller.

Case manager as advocate for patient and hospital

As the liaison between the patient/family and hospital, the case manager can help the hospitalist keep a treatment plan on track and suggest modifications in often highly dynamic situations. In this capacity, says Daniels, the case manager can ask key questions such as, “Is the patient receiving the kind of service that is warranted based on the prognosis and the family’s wishes?” and “What are the options and risks that the patient should know about?”

During hospitalization, the case manager can function as the patient’s advocate as issues develop. For example, if a decision about surgery or treatment is on hold until a magnetic resonance imaging (MRI) screen is performed and a patient is becoming increasingly anxious about the potential for surgery the following morning, a case manager can “cajole, beg, and bargain with people in scheduling to make the MRI more timely,” Daniels says. “No matter how you design the program, case managers...”
help doctors and nurses be more effective in getting a patient through a complicated system," says Miller. For the past six years, case managers at Danbury Hospital were assigned to physicians, but now with hospitalists caring for patients scattered all over the hospital, Miller says the facility has returned to its former model of assigning case managers to units.

Although case managers are a hospitalist’s allies, at their best, they will also challenge and question a hospitalist when appropriate. “They are there to guide, inform, and suggest alternative practices when appropriate,” says Daniels. “Case managers never interfere in clinical judgments but are prepared to challenge practice decisions.”

Case managers also keep a sharp eye on the hospital and the patient’s best financial interests. If a hospitalist prescribes an expensive medication and the case manager knows that the patient won’t be able to afford it, he or she will bring that to the hospitalist’s attention and suggest a more affordable alternative, Daniels says.

Daniels remarked that research has shown that in cases of community-acquired pneumonia, it takes 10 days for the antibiotic to work. However, many physicians continue to order an x-ray every day. “They [may be] doing it out of habit,” she says.

The case manager is also there to ask the physician, “Are you going to change the treatment as a result of that test?” Daniels says. For example, if the patient and family have accepted hospice care, the case manager will remind the hospitalist that additional testing is not aligned with the patient’s wishes.

According to Daniels, many hospital CEOs want case managers to question practice decisions that do not appear to contribute to desired outcomes.

“[Many nurses] are not 100% comfortable questioning these things.”

Two years ago, case managers at Danbury Hospital started working with physicians to improve documentation on hospitalizations so the hospital could improve its reimbursement rates for the services it provided, says Miller. Just as case managers will assess the appropriateness of admission, they also now assess the appropriateness of continued hospitalizations, he says.

With their knowledge of the reimbursement policies of payers, case managers remind the hospitalist to document and justify in the patient chart the reasons for continued hospitalization so payers won’t deny the charges.

An additional benefit that case managers bring to the table is continuity of care, Daniels says. Although today’s patients may see many different nurses, specialists, and other healthcare practitioners during the course of their hospital stay, in addition to having just one hospitalist, they will also have one case manager. Such familiarity will also likely make patients and families feel more at ease and may prompt them to raise questions and concerns that they would not otherwise mention.

A hospitalist’s business partner

Daniels encourages hospitalists to view case managers as “business partners” in the delivery of care. As payers move to profile physicians, Daniels says, “We want our hospitalists to be competitive and to be in that bell curve.” Once known as utilization management and now commonly referred to as case management, the emerging term for case managers’ role is “clinical resource management,” according to Daniels.

Noting that hospitalists often work under an incentive arrangement, she warns, “If hospitalists are not taking full advantage of case managers, it may compromise their ability [to receive] full compensation.”
At Emory Health Care (www.emoryhealthcare.org) in Atlanta, where physicians perform transplants and other heroic lifesaving feats of medicine, starting a palliative care program meant spending a great deal of time educating referring physicians. According to a hospitalist and a business manager involved with Emory’s palliative care program, the key to success starts with the basics in terms of informing potential referring physicians about what palliative care is and isn’t.

“One misconception about palliative care is that it’s seen as a deceleration of care, as taking away treatment and taking away things that might help patients,” says Valerie Chrusciel, business manager for the hospital medicine program at Emory. “It’s a hard concept to get around. To go from very much being focused on lifesaving to ‘we’ve done all we can do’ is a hard fence to go over.”

**The growth of palliative care programs**

The Center to Advance Palliative Care (CAPC, www.capc.org) at the Mt. Sinai School of Medicine reports that the number of palliative care programs in the United States has surged in recent years to 1,027 (25% of hospitals) in 2003 from 632 (15% of hospitals) in 2000—a 63% increase. Palliative care programs are more common in larger hospitals, not-for-profit hospitals, academic medical centers and Veterans Administration hospitals as well as in the New England, Pacific, and Mountain regions.

According to the CAPC, hospitals are starting palliative care programs at a rapid clip for several reasons, such as

- meeting the needs of a growing, chronically ill Medicare population
- addressing inadequate treatment of pain, poor communication, and coordination of care
- reducing costs (e.g., moving patients to the most appropriate level of care)

Notably, the Robert Wood Johnson Foundation (www.rwjf.org) has poured millions of dollars into funding palliative care initiatives, including the CAPC.

In announcing the launch of Emory’s palliative care program in November 2005, Mark Williams, MD, professor of medicine at the Emory University School of Medicine and director of the hospital medicine unit, described the goal of the program as “healing at a higher level” that relieves both the physical and nonphysical suffering of patients with serious illnesses. This healing can involve control of pain and symptoms such as nausea, fatigue, and depression; counseling in making difficult decisions; providing emotional and spiritual support; and assisting with coordinating home care, referrals, and other needs.

Emory’s core palliative care team consists of two hospitalists and an advanced practice nurse with a PhD in education, and the team hopes to soon add a nurse practitioner. The service offers inpatient consultation service, and patients who want outpatient palliative service are referred to a geriatrician who practices palliative care.

**Different from hospice care**

Convincing referring physicians that they will not lose control of their patients’ treatment when they partner with a hospitalist program that offers palliative care is one educational challenge. Another is conveying the difference between hospice care and palliative care. “The perception is that you’re the death team,” says Chrusciel. But unlike hospice care, the palliative care program at Emory is not intended to focus on dying patients who have no more than six months to live.

Because Emory’s program is so new, many of the referrals are for end-of-life care, Chrusciel says. However, as the program matures, the palliative care team expects to increasingly work with seriously ill patients who are expected to live for years and can...
Palliative care

benefit from symptom and pain relief as well as emotional support and assistance in making decisions about their healthcare.

Stephanie Grossman, MD, one of two hospitalists who works for the Emory palliative care service, says an important role the palliative care team can play is organizing and facilitating a family discussion. Unfortunately, physicians may not have time to attend because these discussions often last for several hours and involve organizing a large group of people, she adds. However, the consequences of not having a family discussion can be significant. For example, a patient may remain in the intensive care unit for more than a month, and it isn’t until a family discussion takes place that the patient’s desires and goals are made clear, Grossman says. “Often [the patient] doesn’t want prolongation of life as much as quality of life.”

Chrusciel says the effect of a family discussion and the involvement of the palliative team can also be seen in the length of stay (LOS) data. A patient who has lingered in the hospital for months will go home or be discharged to a nursing home or other appropriate venue within days of the palliative care consult, she says.

Continuing education

Emory’s palliative care service already has more referrals than it can handle because physicians have seen its early successes, Grossman and Chrusciel say. In addition to providing referring physicians with initial information about the program, the team has spent a great deal of time educating referring physicians one-on-one about it.

In Florida, Mary O’Donnell, RN, a consultant for the North Broward Hospital District (www.browardhealth.org) and educational specialist for the Barbara Ziegler Palliative Care Program, says that although her program has existed for six years and is one of the oldest in the country, educating physicians and residents about palliative care is an ongoing process.

As part of its continuing medical education program, North Broward Hospital District continuously offers the “Education for Physicians on End-of-Life Care” (EPEC) program, developed by American Medical Association. The sessions include modules about
- best practices in palliative care
- ethical decision-making
- symptom management

Ask the expert: Global surgical fees for specialists

Q: Some surgical specialists (e.g., orthopedists, gastroenterologists, etc.) with whom our hospitalists work have expressed a desire to transition from direct inpatient care to a consultant role. As such, they would consult and make clinical recommendations without being involved in the daily management of the patient in most cases. What would be required of specialists for them to charge the hospitalist service a global surgical fee for this arrangement?

A: The basic requirement for the global surgical fee is to perform the operation and all of the pre- and postoperative care required for an uncomplicated case. It makes no difference whether the surgeon is the physician of record. The hospitalist’s billings on the evaluation and management codes do not affect the surgeon’s fees.

For example, if the hospitalist service cares for a patient postsurgery for a hip fracture, the hospitalist can bill for it because he or she is attending to the fracture (but not doing the surgery). Note that some insurance carriers may demand additional documentation, especially if another physician performed the surgery. As a result, it would be wise to find comorbidities to code.

Editor’s note: Richard E. Rohr, MD, FACP, director of hospitalists at Milford (CT) Hospital, answered this month’s question. Contact him at richard.rohr@milfordhospital.org.
communication
psychosocial issues

All new programs can be threatening to referring physicians, says O'Donnell. It's important to avoid being confrontational and to negotiate. As a result, she advises palliative care team members to reassure referring physicians that their patients will not be taken away from them. “Physicians have more and more time constraints,” she says. “We have the gift of time to listen to their issues.”

The North Broward Hospital District palliative care program, which was started with a bequest to the district and Sloan Kettering Cancer Center in New York for that purpose, has a unique focus on pediatric palliative care—an area that O'Donnell says is frequently overlooked.

**Physician-led palliative care**

Although many palliative care programs are nurse-led, O'Donnell, who began the hospice program at the North Broward Hospital District 25 years ago, says she is a believer in physician-led palliative care because of the immediate intervention. For example, a physician can order prescriptions and alleviate patients' physical discomfort right away, she says. O'Donnell is also a firm believer in full-time staff dedicated to palliative care. In fact, she says the patient census at her facility increased significantly once the palliative care program had full-time staff.

Chrusciel adds that palliative care is time-consuming and that administrators need to be aware that a hospitalist performing palliative care will attend to far fewer patients daily than colleagues who are not. At Emory, whereas the typical hospitalist works with 15–17 patients per day, the palliative care hospitalists work with only four.

Still, Chrusciel says the cost savings that accrue from offering a palliative care service make a compelling argument for administrators, adding that healthcare spending is at its highest in the last five days of a patient’s life. Although a palliative care program appears to be a cost center, it has been shown to produce significant savings in inappropriate care. Chrusciel is collecting data about LOS and the use of ancillary services before and after a palliative care consultation. Another compelling argument is that palliative care can free up hospital beds by moving patients to the most appropriate level of care.

According to Chrusciel, in starting its palliative care program, Emory followed the steps for proposing, planning, and cost-justifying a program that were outlined by the CAPC. She recommends that any organization looking to start a palliative program make use of the resources that the CAPC offers, which include tools for data collection, seminars, a mentoring program wherein hospitals planning a palliative care program are partnered with an existing program for a year.

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Palliative care

("Infrastructure Supports What is Most Important in Palliative Care") outlined some of the major steps facilities should take in planning and creating a palliative care program, including the following:

- **Collecting data**—Clinical, financial, and customer satisfaction outcomes should be tracked to demonstrate the value of a palliative care consulting service. Data collection should be feasible, valuable, and not overly time-consuming.

- **Creating a programmatic model**—Be clear on the palliative care program’s model and on the roles of team members. Address questions such as:
  - What is palliative care at this facility, and how does it differ from hospice care?
  - What is the scope of practice?

- **Delivering care**—Every health institution has a recognized etiquette for medical consultations. The palliative care service should reflect this established protocol. Address questions such as:
  - What is the preferred mechanism for a referral?
  - Does it involve a pager, voicemail, or designated times when the team is accessible by phone?

- **Scheduling**—Based on the hospital’s routines, identify whether certain times of the day are better for teaching, rounding, “curbside consults,” or new admissions. Services should aim for some level of 24/7 coverage, even if only by telephone, because seriously ill patients and their physicians often need assistance during off-business hours.

- **Building a team**—The core palliative care team needs to work on establishing and tending relationships with professionals in social work, chaplaincy, and finance, but also in billing, risk management, patient relations, professional education, and marketing/public relations.

- **Using other resources**—Tap any resources that exist within the organization that can help you in your mission. For example, the palliative care service at Central DuPage Hospital in Winfield, IL, works with a pediatric child life specialist who supports the children and grandchildren of palliative care patients on adult floors.

*Editor’s note: To access the complete Journal of Palliative Medicine article, go to www.liebertonline.com doi/pdf/10.1089/jpm.2005.8.1092.*