SHM survey provides benchmarks for compensation and productivity

From its infancy 10 years ago, hospital medicine now might have entered the exciting yet awkward stage of adolescence, based on the results of the 2005–2006 Society of Hospital Medicine’s (SHM) survey of hospitalists. The society’s third survey finds that hospitalists are earning higher compensation, growing in numbers, increasing in productivity, and becoming more embedded in hospitals and healthcare.

“There is a striking maturation of the field,” says Robert Wachter, MD, chief of the medical service at the University of California, San Francisco Medical Center, who called attention to the budding hospital medicine phenomenon in an August 1996 New England Journal of Medicine article.

Mary Jo Gorman, MD, MBA, member of the physician advisory board of North Hollywood, CA–based IPC–The Hospitalist Company and the current SHM president, says the survey indicates that the field is moving toward its goal of providing care to every hospitalized patient, although she adds that

A business perspective wins the hospitalist friends and influence

Hospitalists are most familiar and comfortable with the language of clinical medicine and patient care. However, to be an effective hospital-based physician, the hospitalist must also learn to speak the language of the hospital’s key business decision-makers, says Mike Guthrie, MD, MBA, management consultant and executive-in-residence at the University of Colorado, School of Business, Program in Health Administration in Denver.

Physicians don’t receive training in finance and economics during medical school, but to be effective and influential in their current and future roles, hospitalists must know what worries the CEO, asserts Guthrie. Hospitalists need to have a working business vocabulary so they can communicate the value of what they do—and how it fits in with the hospital’s overall goals—in terms that administrators can readily grasp.

“It’s easy to be dismissive of administrators as ignorant and unappreciative civilians,” who are more concerned with the bottom line than with patient
there is some debate about whether this goal should apply to obstetrics and gynecology patients.

The initial expectation for the field, she says, was that primary care physicians (PCP) would be the major source of patient referrals to hospitalists. In the survey, 95% of hospitalists report getting referrals from PCPs and 99% report doing consultations, which means that many specialists are also now referring patients to hospitalists, she says. “That 99% are doing consultations is great for patients,” Gorman notes.

**Compensation and productivity**
The SHM survey, based on the responses of 396 hospital medicine groups (HMG), represents 2,550 hospitalists—or approximately 17%–20% of the nation’s hospitalists. The 292-page report provides data on the characteristics of hospitalists and HMGs, coverage arrangements, staffing, compensation, productivity, work responsibilities, financial support of programs, and more.

But Joe Miller, senior vice-president for SHM, says the most relevant data for many hospitalists are the data on compensation and productivity.

“[They help] set the bar and provide a benchmark,” says Miller, who cautions that compensation data must be used in the context of workload and productivity. The average compensation for hospitalists is $169,000, according to this survey, an 8% increase from two years ago when it was $156,000. The average value of benefits also increased about 8% to $27,000.

“I expect that [the rise in compensation] will continue for some time because there is so much demand,” Gorman says, noting that the rise is comparable to the increase in relative value units (RVU) worked by hospitalists annually (a 7% rise to 3,213 RVUs from 3,000 in the last survey). The annual number of patient encounters by hospitalists also increased, by 3% to 2,328 from 2,259. The survey shows a clear trend toward a compensation model that is a mix of salary and pay based on performance or productivity. About 67% of hospitalists are paid under this mixed model, up 20% from the last survey (47%). Likewise, those paid salary only decreased to 28% from 41%. Gorman notes that hospitals have learned that like many employees, physicians are more productive if their compensation package includes incentives based on performance.

**Financial support by hospitals**
Of hospitals surveyed, 97% contributed to the support of hospital medicine groups. The groups receive approximately $50,000–$60,000 per hospitalist in financial support, roughly equivalent to the $60,000 reported in the 2003–2004 survey.

Will hospital medicine programs ever become self-supporting? There’s little indication that this will happen very soon. One point of view, Gorman says, is that it’s only fair that hospitals support hospital medicine programs given the expectations that hospitalists spend a lot of time on nonclinical activities (e.g., quality improvement programs, serving on committees, etc.) and are taking on a greater role in disaster planning and setting up new information systems.

“If the hospital has a big project or needs extra help, the feeling is that it should pay for it,” she says. Alternatively, some feel that hospital medicine groups should share in the financial benefits that their program earns for the hospital. “Regardless of your point of view, what we have to be worried about is if this support is going to be sustainable,” Gorman says.

“There is always a concern that hospitals recognize the value hospitalists produce . . . As programs grow and expend more money, hospitals find it harder to dig deeper in pockets. It’s a constant battle.”

—Joe Miller
The changing demographics of hospitalists and practice groups

The median age of hospital medicine groups is now four years and the median age of hospitalists is 37 years. For hospital medicine group leaders, the median age is 41 years.

As hospital medicine develops, other characteristics of hospitalists and hospital medicine groups are evolving. Robert Wachter, MD, chief of the medical service at the University of California, San Francisco Medical Center, says when he first spotted the trend of hospital medicine, he expected that many of its practitioners would be specialists. In fact, most are generalists, with 75% from internal medicine.

A growing number of hospitalists are practicing in rural communities—about 18% of hospital medicine groups say they practice in rural areas.

About 15% of hospitalists now identify themselves as pediatric-only hospitalists. According to Mary Jo Gorman, MD, MBA, member of the physician advisory board of North Hollywood, CA–based IPC–The Hospitalist Company and the current president of the Society of Hospital Medicine, the growth in pediatric hospital medicine is an interesting trend given the relatively low volume of pediatric patients. A 300-bed hospital that typically has 50–75 obstetrics and gynecology beds will have only 15 pediatric beds, she adds. Few children have serious health problems, and those who do come to the hospital are generally released quickly, she says. It is usually only children with cancer or other serious medical conditions who require hospitalization.

Another characteristic that is changing is that hospitalist-only groups are clearly gaining favor as providers of hospital medicine compared to multispecialty groups, says Gorman. In the early years of the hospitalist movement, “many groups thought, ‘anyone can do this. We have internists. We can throw something together.’ But it’s not as easy as it looks,” Gorman asserts.

In 2006, 31% of hospitalists were employed by hospitalist-only groups compared with 14% employed by multispecialty/primary care physician (PCP) groups. In 2000, only 12% of hospitalists were employed by hospitalist-only groups compared with 24% employed by multispecialty/PCP groups. From 2000 to 2005, the number of hospitalist programs that were part of multispecialty/PCP groups remained relatively unchanged while there was explosive growth in the hospitalist-only model during that period.

Wachter says that although the hospitalist movement started mostly in community hospitals, the recent SHM survey shows that more and more hospitalists work in the academic setting. In the new survey, 20% of hospitalists worked in academic settings compared to 10% in 2000. Wachter attributes the increase to efforts by the AGME to address concerns about overworked residents. “The meteoric growth in those settings has been driven by limits on the house staff’s hours,” says Wachter. “There is a tremendous need to replace the house staff’s work.”

### Facts about hospitalists

| Median age: Hospital medicine groups (HMG): | Four years |
| Non-leader hospitalist: | 37 years |
| Hospitalist leader: | 41 years |
| Gender: HMG leaders: | 80% male, 20% female |
| Non-leader physicians: | 62% male, 38% female |
| Experience: HMG leaders: | 5.1 years |
| Physician nonleaders: | 3 years |
| Number of beds in affiliated hospitals: | 321 beds |
| Specialty: General internal medicine: | 75% |
| General pediatrics: | 11% |
| Internal medicine subspecialty: | 4% |
| Family practice: | 3% |
| Internal medicine pediatrics: | 3% |
| Pediatric subspecialty: | > 1% |
There’s growing interest by hospital medicine programs in reaping some of the financial benefits of reducing length of stay and other improvements in patient care. If hospital medicine programs—through joint venturing, pay for performance, or other incentive programs—could share in the financial gain, it would be easier for hospitals to “directly tie what hospitalists do to additional revenue,” Miller says.

Wachter, who heads a program of 24 hospitalists at the University of California, San Francisco, doubts that the reimbursement system will ever compensate hospitalists for the coordinative roles that they play.

He warns that every program should brace itself for “a near-death experience.” His own program’s experience occurred five years ago, when Wachter, whose staff then numbered 17, was told his budget would be cut by one-third.

According to Wachter, the question you must ask yourself is “should we work that much harder or do we push back?” Wachter says that he decided to push back and take a stand that the program would have to be cut in proportion to the budget. The hospital didn’t want to give up the equivalent in staff and services and backed off from the draconian cut, he says. “I not only felt it was in our own group’s interest, but in the hospital’s,” he says. “They blinked and gave us what we needed.”

Wachter says hospitalist leaders must be prepared for that battle and be able to demonstrate evidence-based arguments for maintaining or expanding the program. “There is always this tension and it’s inevitable [that] you will come at loggerheads,” Wachter says.

Editor’s note: For a full copy of the SHM survey, call 800-843-3360 or visit www.hospitalmedicine.org.

—Eliot Fishman

Perspective

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and through other people to get things done,” Guthrie says. As a member of a care team trying to solve complex problems, your expertise doesn’t necessarily carry more weight than the expertise and insights of others. If they are speaking Greek and you are speaking Latin, he says, you must be able to translate to a common language so that you can communicate constructively.

For hospitalists who hesitate to enter the business realm, Guthrie notes that taking a business perspective doesn’t mean that you are compromising yourself as a clinician or being brainwashed to view things from only the administration’s perspective. It just demonstrates that you are flexible in your thinking and allows you to be more effective in influencing and shaping the hospital’s agenda. “You are able to have that conversation constructively and persuasively,” he says. To be influential, you must be able to listen, understand, and communicate in the other person’s language.

The perspective of the effective administrator is broad. He or she assesses the dynamics and challenges of the healthcare environment and responses that are necessary in the organization to ensure that the hospital will survive and sustain itself. One of the key concepts that hospitalists need to appreciate is business drivers, Guthrie says.

Business drivers are the external influences in society and the market that significantly affect or set the direction for the hospital. These drivers both generate the problems that need to be solved and create the hospital’s objectives in solving them. Examples of business drivers include

- the nation’s aging population
- shifts in insurance coverage
- population growth
- geographic changes in physician distribution
- technological advancements
- the rise in consumerism

When Guthrie speaks to groups of physicians, he frequently conducts an exercise in which the participants break up into small groups and list business drivers in one column, associated hospital objectives in another, and how these two items affect the hospitalist in the final column. This exercise helps hospitalists relate their own plans and goals to the top concerns of the organization. For example, decreases in reimbursement and shifts in insurance coverage impel the hospital to set objectives for managing the length of stay (LOS). This, in turn, leads the hospitalist to manage selected populations of patients more effectively to minimize errors and outliers.

Understanding cash flow

According to Guthrie, another key business concept that hospitalists must learn to grasp is incremental cash flow. Any change in the relative expense of care in relation to (usually fixed) income from reimbursement has an effect on cash flow. The value of excellent patient care and improvements has to be translated into negative or positive cash flow for the organization.

In proposing the use of new guidelines for pneumonia patients, for example, hospitalists can make the business case for that intervention, he says. If the intervention requires additional resources in staff, time, or equipment, it’s important to not only point out the potential for reduced LOS, for example, but also the potential to reduce the number of outliers and the number of days patients spend in the intensive care unit as the overall potential for cost savings. Even more effective, present financial data to administrators showing these benefits with the hospital’s current numbers, Guthrie advises. “Outliers cost the hospital a lot of money,” Guthrie says. The patient-care argument is just one argument—the hospitalist needs to demonstrate the value of a new program to the organization from financial and other perspectives.

By understanding the executive’s line of sight, hospitalists can anticipate what will be expected of them and be responsive to the hospital’s objectives. In turn, the hospital is more likely to support initiatives and programs advocated by hospital medicine and to appreciate the contribution the hospital medicine program makes to the organization’s vitality and future success.
Coding conundrum:

How hospitalists can avoid common errors when billing for subsequent hospital care

As the physician who is always in, the hospitalist frequently bills Medicare and other payers for providing subsequent hospital care to patients during their hospital stays. Incidentally, subsequent hospital care tops the list of coding problems that the Centers for Medicare & Medicaid Services (CMS) identifies in its Comprehensive Error Rate Testing program and Hospital Payment Monitoring Program, both established by CMS to monitor the accuracy of payments made on behalf of Medicare patients.

Scope of the problem

All three levels of subsequent hospital care, from least to most complex (codes 99231 to 99233), appear on CMS' top-20 list of services receiving improper payments due to insufficient documentation, according to CMS' May 2006 report Improper Medicare Fee-for-Service Payments, which is based on reviews of thousands of Medicare claims.

Editor’s note: “Insufficient documentation” means that the provider excluded essential facts about the patient (e.g., overall condition, diagnosis, extent of services performed, etc.) in the medical record documentation submitted.

The payment error rate was 7.8% for 99232 (moderate complexity) for projected improper payments of $175 million in 2006, 7.3% for 99233 (high complexity) for projected improper payments of $86 million in 2006, and 6.7% for 99231 (low complexity) for projected improper payments of $32 million for the period from July 2004 to June 2005.

Common coding errors

One common mistake that hospitalists make when documenting subsequent hospital care is failing to document the patient's current status, says Charleen Porter, BA, MA, CPC, healthcare consultant and billing and coding consultant for VEI/IMM, a practice management firm affiliated with the Community Health Network in Indianapolis.

Hospitalists must indicate the severity of the patient's problems at that visit, she says. “You have to tell me your thinking process for why the patient needs this high level of care. I've seen physician notes that say ‘patient looks better today,’ ” Porter adds. “Then why are they still at a level 3 service?”

Porter says physicians are under time constraints and often keep documentation to a minimum, which can contribute to billing errors. However, she advises hospitalists to document more methodically—similar to residents who are new to the process. For example, it might seem redundant to hospitalists to include test results in their documentation, but Porter adds that auditors might not receive test results as part of the documentation on the claim. Also, many first-line auditors don’t have a clinical background.

Porter says the days when physicians could write “the patient looks good,” perform a minimal exam, leave orders to “continue present management,” and then charge for a level 3 service are gone. “If you’re going to keep the reimbursement, you need to put a little more on paper,” she says. Adding information about comorbidities to the record may allow the hospital to bill for a higher level of service, Porter notes.

“Tapering down” of patient care

Lynn Hickman, MD, Louisiana and New Mexico medical director for Oklahoma City–based Pinnacle Business Solutions, Inc., a Medicare carrier and intermediary, says patients typically should not receive level 3 service for their entire hospital stay.

In the first days of a patient’s hospitalization, you might expect to see coding for level 3 subsequent hospital care, but generally there should be a “tapering down” of the level of service, particularly just prior to discharge, Hickman says.
“If you are coding correctly, there should be continuing improvement with less visit time and less work involved in management,” says Hickman.

“It is reasonable to expect higher levels of history and physical [H&P] exam to be needed in the days immediately following a hospital admission; following transfer from intensive care; or following an acute exacerbation, complication, or decompensation of the patient’s condition(s),” wrote Hickman in the May 2004 Medicare Providers’ News.

“It is not expected that these higher levels would be medically necessary when the patient is stable and improving, particularly in the visits on days preceding discharge from the hospital. Documentation of H&P examinations and medical decision-making should not be performed or billed at levels greater than needed for the patient’s condition,” Hickman says.

Porter adds that some specialists say they should only see patients requiring level 5 outpatient visits. Likewise, some hospitalists feel that they should only be working at level 3. Porter responds to such assertions by saying, “Not everybody that you visit is on the verge of demise or organ failure.”

CMS has identified the practice of billing subsequent hospital care that’s unsupported by the patient’s condition as a nationwide problem. In a review of claims for oncology patients in Oklahoma from May to September 2005, for example, reviewers found that the extent of documented H&P exams was greater than the levels required by the patients’ conditions. Subsequently, 78 of 237 services were recoded to 99231.

Using templates and training to code better
At the University of Pennsylvania Health System, Mary Mulholland, RN, CPC, MHA, from the Office of Clinical Documentation for the Department of Medicine, says her hospital has developed templates to guide physicians in providing accurate documentation. Providers can choose to use either Medicare’s 1995 or 1997 guidelines for documentation. She prefers the 1995 examination guidelines, calling them “less onerous.” The 1995 examination guidelines provide the physician with the flexibility to document the

Ensure coding at the correct level for subsequent hospital visit
Subsequent hospital visits require two of three key components of the history and physical, patient examination, and medical decision-making process. Current communication from the Centers for Medicare and Medicaid Services (CMS) indicates that when a level 3 subsequent visit is chosen, the practitioner must demonstrate high-complexity medical decision-making.

The Current Procedural Technology book published by the American Medical Association describes the level 2 subsequent hospital visit (99232) as typically consisting of “25 minutes at the bedside and on the patient’s floor or unit.” The level 3 subsequent hospital visit (99233) typically consists of “35 minutes at the bedside and on the patient’s hospital floor or unit.” If more than 50% of the time spent face-to-face with the patient is consumed by counseling the patient or family regarding the patient’s management, prognosis, etc., or in coordination of care, the service can be billed using time as the key component.

The total visit time and the time spent in counseling or coordination of care activities should be documented in the record (e.g., total visit time was 35 minutes; time spent counseling regarding xyz was 15 minutes).

Source: Tools and Strategies for an Effective Hospitalist Program, published by HCPro; Chapter 11: “Coding and compliance for the inpatient physician.” For more information, visit www.hcmarketplace.com/prod-4013.html.
examining points most specific to the needs of their patients, she says.

“If you are an auditor or abstractor, you use lists and reminders for documentation when coding physician services. Physicians generally don’t have lists, and they are often interrupted when documenting their services,” she says. A template assists providers in documenting the key components of the evaluation and management service. The template also reminds them about basic steps (e.g., documenting the date and duration of service, signing their clinical notes, etc.). Mulholland says use of templates helps save valuable provider time, improves the detail included in the documentation of the encounter, and improves efficiency.

Mulholland and Hickman stress the importance of taking advantage of the coding training provided by professional societies and Medicare carriers. To avoid being an outlier on billing for level 3 subsequent hospital care—thereby increasing your chances for an audit—Porter recommends that you obtain a comparative billing report from your local Medicare carrier. These reports enable physicians to compare billings on a specific code or code ranges to peers in the same state with the same or similar specialty types. To be paid correctly, physicians must provide more detail in chronicling patients’ problems and their severity, and must also better document their medical decision-making and the appropriate level of assessment, says Porter. A complete record not only helps ensure reimbursement, but also benefits patients and colleagues, she adds.

Porter’s outlook lends credence to the fact that hospitalists should take the time to become well versed in proper coding and billing procedures. “I don’t see anybody cutting anyone any slack. [Payers are saying], ‘We want to know what we’re paying for, and the only way we’re going to know is if you’re telling us. We’re not going to make any assumptions.’ ”

Editor’s note: See p. 9 for a chart containing examples of low-, moderate-, and high-risk evaluation of patients’ presenting problems, as well as relevant diagnostic test orders and management options (from Tools and Strategies for an Effective Hospitalist Program, HCPro, Inc., 2006).

### Codes describing subsequent hospital care

Codes 99231–99233 describe subsequent hospital care and require documentation of the interval history at either the problem-focused, expanded problem-focused, or detailed level.

The examination requires the same levels of documentation. The documentation must support straightforward low-, moderate-, or high-complexity medical decision-making. The nature of the patient’s presenting problem usually determines the level of history and physical exam required.

1. Current procedural technology (CPT code) 99231 usually requires documentation to support that the patient is stable, recovering, or improving.

2. CPT code 99232 usually requires documentation to support that the patient is responding inadequately to therapy or has developed a minor complication. Such minor complications might include careful monitoring of comorbid conditions requiring continuous active management.

3. CPT code 99233 usually requires documentation to support that the patient is unstable or has a significant new problem or complication.

## Low-, moderate-, and high-risk examples

<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Presenting problems</th>
<th>Diagnostic procedures ordered</th>
<th>Management options</th>
</tr>
</thead>
</table>
| **Low**       | • Two or more self-limited or minor problems  
• One stable chronic illness (e.g., well-controlled hypertension or noninsulin-dependent diabetes, cataract, BPH)  
• Acute uncomplicated illness or injury (e.g., cystitis, simple sprain, allergic rhinitis) | • Physiologic tests not under stress (e.g., pulmonary function tests)  
• Noncardiovascular imaging studies with contrast (e.g., barium enema)  
• Superficial needle biopsies  
• Clinical lab tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| **Moderate**  | • One or more chronic illnesses with mild exacerbation or progression, or side effect of treatment  
• Two or more stable chronic illnesses  
• Undiagnosed new problem with uncertain prognosis (e.g., breast lump)  
• Acute illness with systemic symptoms (e.g., pneumonitis, colitis, pyelonephritis)  
• Acute complicated injury (e.g., head injury with brief loss of consciousness) | • Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)  
• Diagnostic endoscopies with no identified risk factors  
• Deep needle, incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)  
• Obtain fluid from body cavity (e.g., lumbar puncture, culdocentesis) | • Minor surgery with identified risk factors  
• Elective major surgery (open, percutaneous, or endoscopic)  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| **High**      | • One or more chronic illnesses with severe exacerbation or progression or side effect of treatment  
• Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)  
• Abrupt change in neurologic status (e.g., sensory loss, seizure) | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open, percutaneous, or endoscopic)  
• Emergency major surgery (open, percutaneous, or endoscopic)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to deescalate care because of poor prognosis |

*Source: Tools and Strategies for an Effective Hospitalist Program by Jeffrey R. Dichter, MD, and Kenneth G. Simone, DO.*

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Hospitalists a cornerstone of technology, pay improvements in U.S. healthcare system

Hospitalists will play a significant role in federal programs driving the systemic and long-term improvement of the U.S. healthcare system, according to Carolyn M. Clancy, MD, director of the Agency for Healthcare Research and Quality (AHRQ), an organization whose mission is to improve healthcare quality, safety, and efficiency.

Clancy, who spoke during the Society of Hospital Medicine’s annual conference in Washington, DC, asserted that the continued growth of hospitalist medicine is essential to the issues of patient safety, health information technology (HIT), and quality improvement via initiatives such as pay for performance (P4P). “I don’t think we can [do it] without the involvement of this society,” Clancy said.

Striving to “HIT” the mark on quality

Clancy, a general internist and health services researcher who has led the AHRQ since February 2003, said one of the agency’s primary focuses is the intersection of HIT and quality.

According to the AHRQ’s Web site (www.ahrq.org), the HIT initiative includes more than $166 million in grants and contracts in 41 states to support and stimulate investment in HIT, especially in rural and underserved areas. Through these and other projects, the AHRQ and its partners are identifying challenges to HIT adoption and use, proposing solutions and best practices for making it work, and creating tools to help hospitals and practitioners incorporate the technology.

Although it’s encouraging that some organizations are implementing more healthcare technologies (e.g., electronic health records, computerized physician order entry, etc.), Clancy said the incompatibility among various healthcare systems creates problems.

“HIT can make a big difference in improving quality and safety, but the bad news is that most [healthcare organizations] are using homegrown systems,” Clancy explained. “Every organization is creating [its] own script as we go.”

According to Clancy, the nation’s hospitals must strive for interoperability. A compatible and connected network could allow patients’ personal data to follow them wherever they seek healthcare treatment. She likened such a system to those implemented by state highway systems. “It’s like the easy passes for interstate tolls that we have up and down the East Coast,” she said.

The AHRQ’s agenda with regard to modernizing...
Recruiting tip of the month: How to close the deal

Your hospitalist candidate has completed the on-site interview process and you’ve begun your wrap-up session. At this stage, it’s best to provide the candidate with personal, direct, and meaningful feedback.

Comments that you should incorporate into your closing conversation include the following:
- “We really like you and feel that the interview went very well.”
- “We believe that you’d be a tremendous fit for our hospitalist program.”
- “Are there any issues that came up today that we should address?”
- “What are your thoughts about the position and the organization?”

Closing the deal ultimately comes down to knowing your hospitalist candidate both professionally and personally. A physician is most likely to accept a position if it offers a better career path, promotion, or better lifestyle. Through candid conversations, you can learn about one’s professional and personal goals, and identify what opportunities your organization can provide to better his or her current situation.

If the candidate portrays a positive attitude and likes the organization, position, salary, and community, you might want to ask, “If we were to make you an offer, what would you say?”

If the candidate is prepared to make a decision, you might want to cut and close. In that case, if you’ve done your reference checks, you’re home free.

Editor’s note: This tip was submitted by Paul Smallwood, vice president of physician search with St. Louis-based Cejka Search, a nationwide firm that specializes in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800-678-7858.
Critical-care physicians may be in short supply in the coming decade

In a report released May 22, the Health Resources and Services Administration (HRSA, www.hrsa.gov), a branch of the U.S. Department of Health and Human Services, predicts that the supply of physicians who specialize in treating critically ill patients likely will not meet the demand in the next decade.

According to the report, myriad factors are predicted to strain the demand for intensive care unit (ICU) services in the coming years, including:

- the rapid growth in the number of elderly patients
- an increase in the acuity of the average hospitalized patient
- a decrease in the availability of highly trained healthcare practitioners

Today, there are roughly 2,000 critical-care physicians (also called intensivists) working in U.S. hospitals.

However, the HRSA predicts that the expected supply of 2,800 critical-care physicians in 2020 will fall far short of the needed 4,300 such physicians. According to the report's executive summary, patient-safety-focused organizations such as the Leapfrog Group (www.leapfroggroup.org) have advocated for the increased use of critical-care physicians in ICUs of acute-care facilities. Their advocacy is based on a growing body of research finding that patients under the care of critical-care physicians have better outcomes.

According to the HRSA, currently only one-third of critically ill patients receive care from critical-care physicians. However, some predictions for the coming decade suggest that these physicians could direct the care of two-thirds of all patients in the ICU.

The HRSA conducted the study in response to a 2003 request from Congress to analyze whether the country would have a sufficient number of critical-care physicians in the intermediate-term future.

To read the complete report, go to www.chestnet.org/downloads/practice/gr/HRSAReportMay06.pdf.