Hospitalists’ must-read list puts focus on developing leadership skills

Hospitalists always have plenty of clinical reading to do, but to become effective leaders in their respective programs and in the field of hospital medicine at large, their reading should also include titles that are on the must-read lists of many top business executives, experts say.

As a result, the Society of Hospital Medicine’s (SHM) leadership committee is constructing a recommended reading list to help hospitalists cultivate their leadership skills. The list will include fewer than 20 works and is slated to be posted on the society’s Web site (www.hospitalmedicine.org) by the end of the year, says Russell Holman, MD, national medical director of Cogent Healthcare, president-elect of SHM, and the founder and former chair of the leadership committee.

In the following preview of the list, Holman cites five of his personal favorites. He recommends not only management books, but also reports and articles from the healthcare field that he

Communication and negotiation key to hospitalist/specialist collaboration

When a patient must be admitted to the hospital, hospitalists and specialists often conduct tug-of-war negotiations to work out the roles that each physician will fulfill during the patient’s stay. Typically, this results in hospitalists feeling pressured to act as the patient’s attending physician, rather than the specialist taking that role.

Hospitalists’ eagerness to provide “added value” to the hospital and medical staff can sometimes backfire if specialists and other providers take advantage of this goodwill. In fact, hospitalists’ willingness to go above and beyond the call can lead specialists to avoid taking attending physician responsibility for patients, says Ken Simone, DO, founder and president of Brewer, ME–based Hospitalist and Practice Solutions. Simone contends that specialists increasingly play a proceduralist role in patient care.

According to the most recent survey by the Society of Hospital Medicine (SHM), 11% of hospitalist leaders cited specialists’ unavailability for consultation as a top problem for their program.
believes are required reading for all hospitalists and hospitalist leaders.

1. Good to Great: Why Some Companies Make the Leap and Others Don’t, by Jim Collins

“Good is the enemy of great,” Collins writes in his opening chapter. “And that is one of the key reasons why we have so little that becomes great. We don’t have great schools, principally because we have good schools. We don’t have great government, principally because we have good government. Few people attain great lives, in large part because it is just so easy to settle for a good life.”

“This is the best management book that has been written in the past several years,” says Holman. With the help of a team of researchers, the author studied 11 companies that made the transition from being good to being great. Hospitalist leaders can use the framework developed from the author’s analysis of the shared characteristics of these companies in their own organizations, Holman says. “Many of the concepts in the book have permeated the language of managers,” he says, such as the phrase “having the right people on the bus.” An organization not only needs to hire the “right people,” it also needs them to play the right roles. “It’s not sufficient to have the right people,” Holman adds. “[You must also] have them in the right seat on the bus.”

And the wrong people need to get off the bus, voluntarily or involuntarily, Holman says. “Sometimes, [which individuals] leave the organization can be just as powerful as who stays or who comes into the organization,” he says. Another key concept from the book is that of the “hedgehog,” Holman says. This concept entails identifying what is truly unique and special about your organization that also holds the potential for its greatness.

“Inherent in the mission of a hospital is to attend to the health and well-being of patients and the community,” Holman says. “This is a very lofty and noble purpose,” but it lacks specificity, he adds. It is easier for physicians to recognize a more defined goal or aspiration, such as providing an oncology center of excellence or offering outstanding surgical comanagement services. “You cannot be all things to all people,” Holman says. “The organization needs to focus on things it can do well.” For example, although a hospital medicine program may commit to offering excellent surgical comanagement services, it could decide not to pursue a rigorous clinical research agenda, Holman says.

2. Leading Change, by John P. Kotter

Published by the Harvard Business School Press in 1996, Leading Change outlines an eight-stage model based on Kotter’s study of why businesses fail when they try to make significant changes. A common mistake that leaders make is failing to spend significant time “defrosting” the status quo before moving forward in changing their organizations, Kotter writes.

The first four steps of the model are devoted to preparing for change by softening the status quo. In this stage, leaders need to establish a sense of urgency, create a “guiding” coalition, develop a vision and strategy, and communicate the change in vision, Kotter writes. Only then should they move on to the next four steps, which focus on introducing and institutionalizing new practices in the organization.

“Leading change is what [hospitalists] do every day,” Holman says. “What hospitalists do is work within an environment that is embedded in tradition and resistant to change on multiple levels.”

—Russell Holman, MD

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increasing physician reimbursement is a change that is needed, in reality there are plenty of money and resources in the system, Holman says. The problem is that money and resources in the system are being wasted.

The principles in *Leading Change* can be helpful to hospitalists and hospitalist leaders, whether they are working on change at the micro or macro level, Holman says.

3. *To Err is Human and Crossing the Quality Chasm, by the Institute of Medicine*

A visual image for the sense of urgency that an organization must have before it can implement change is the “burning platform,” Holman says. If an oil rig in the middle of the ocean catches on fire, the crew may not want to take the leap into water, but they also “can’t risk continuing to endure the status quo,” he adds.

The Institute of Medicine’s (IOM) 1999 report *To Err is Human*, which estimated that 48,000–98,000 lives are lost annually to medical errors, is an example of a burning platform, Holman says, adding that it also provides a great place to begin when leading change in an organization. “If the idea is that every system is designed to get the results that it gets, then a system that results in 50,000–100,000 deaths every year needs systemwide change.”

*To Err is Human* provides the substance behind the need for leading change, he adds. *Crossing the Quality Chasm*, published in 2001, followed *To Err is Human* and presented a sweeping vision and plan for improving the quality of healthcare.

According to Holman, *Crossing the Quality Chasm* was the first report to present quality in a much broader context than simply using traditional technical and clinical terms to cover such questions as, Did the patient get the right test or the right medication for his or her illness?

Every hospitalist should have the IOM’s six aims of improvement committed to his or her memory, Holman advises, which are that healthcare is

- safe
- timely
- effective
- efficient
- equitable
- patient-centered

Holman notes that the final goal—achieving patient-centered care—is often the most difficult of the six to realize.


Two articles by James Reinertsen, MD, published in the *Annals of Internal Medicine*, also deserve a place on the required reading lists for hospitalist leaders, says Holman.

In “Physicians as Leaders in the Improvement of Healthcare Systems” (1998;128:833-838), Reinertsen, a rheumatologist who became the CEO of Park Nicollette Health Systems in Minneapolis and subsequently the CEO of CareGroup in Boston, outlines the characteristics of leaders and provides a primer for physicians on how to lead well.

“In Zen and the Art of Physician Autonomy Maintenance” (2003; 138:992-995), Reinertsen makes the argument that the only way physicians can regain their autonomy is paradoxically by giving up their individual autonomy and collectively practicing evidence-based medicine.

“[Physicians] do not practice medicine within the evidence available to us,” says Holman. Physicians can regain the autonomy that they feel they are losing to regulators and administrators by getting behind guidelines on which they can agree as a group, Reinertsen argues.

“[Physicians] are losing [their] clinical autonomy in part because the public has learned that one basis for it—the power of our scientific knowledge—is not being consistently applied for their benefit,” Reinertsen writes.
Length of stay for hospitalists’ patients: Should national standards apply?

Q: What is the national benchmark for length of stay (LOS) for hospitalists’ patients?

A: There are no national benchmarks for LOS because case mix varies significantly from hospital to hospital. In addition, LOS may vary geographically based on the managed-care penetration and insurer mix, as well as all of the associated financial pressures that result.

Research conducted by Joseph Miller, senior vice president of the Society of Hospital Medicine has demonstrated that hospitalist programs are responsible for a 15% reduction in adjusted LOS at their respective institutions.

However, one must proceed with caution when setting a goal or analyzing the reduction in LOS. Once you have maximized the efficiency of your hospital and hospitalist program (with resultant reduction in LOS) any further drop in LOS may have a deleterious effect on patient care, as it may indicate premature discharge.

Editor’s note: Jerry Massey, director of operations at Morton Plant North Bay Hospital in New Port Richey, FL, submitted this month’s ask-the-expert question, which was fielded by Kenneth G. Simone, DO, founder and president of Brewer, ME–based Hospitalist and Practice Solutions. Simone can be reached at ksimone@sunburypc.com.
Specialists

The ambiguity surrounding attending physicians’ roles versus consulting physicians’ roles is one of the most difficult issues that hospitalists face on a daily basis.

One reason is that negotiations often take place on an uneven playing field, says David Grace, MD, hospitalist practice director for the Lafayette, LA–based Schumacher Group. “A new [physician] out of residency who is the low man on the totem pole” is often pitted against a seasoned neurosurgeon who has been practicing for many years, he adds. At night, the specialist is typically reachable only by phone, whereas the hospitalist is already on-site and available to admit and attend to the patient.

Simone points out that residency training programs (e.g., family medicine, internal medicine, surgery, etc.) usually have well-defined guidelines about who will assume the attending physician role. In non-training institutions, “having a clearly defined scope of service [for hospitalists] would certainly diminish any misunderstanding and ill will,” he says. Ideally, mapping out “who does what” should be worked out before patients are admitted, with each of the services clearly laid out in policies. However, many hospitalists find that they must frequently negotiate their roles with specialists on the fly.

Although there are no easy answers to the thorny consult-versus-attending dilemma, three hospitalists—Simone, Grace, and Andras Koser, MD, MBA, a hospitalist at Spartanburg (SC) Medical Center—share the following tips for negotiating with specialists regarding patient care and alleviating conflicts over scope of practice:

1. **Ask for it in writing.** For example, if a patient presents with an intracranial bleed, the neurosurgeon examining the patient’s computerized axial tomography scans from home may find it sufficient to assure the hospitalist that it is clear from the scans that the patient simply needs medical management, Grace says.

However, if the neurosurgeon wants the hospitalist to fulfill the role of attending physician for the patient based on an assessment from home that the patient does not need surgery, Grace says he asks the neurosurgeon to put that opinion in writing. Frequently, that request brings the specialist to the patient’s bedside for an evaluation, Grace says. Once the neurosurgeon has seen the patient and determines that surgery is not needed, Grace says he feels comfortable fulfilling the role as attending physician for that patient.

2. **Clarify roles at the point of transfer.** “Some practices require the referring provider—in this case the specialist—to complete an intake form.”

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defining very clearly and specifically [his or her] request and expectations,” says Simone. Specialists would check off one of the following orders:

- Transfer care with active participation
- Transfer care and follow up as needed
- Transfer care and sign off

Simone says it is important for hospitalists to continue communicating with the specialist after the transfer/discharge. “The hospitalist should always keep the key providers, such as primary care physicians and specialists, involved.”

3. Listen to your gut. With regard to stepping in for specialists, Grace says, “It comes down to whether, as a primary care doc, I feel happy in my gut to be the attending.” He adds that a hospitalist’s level of comfort with each unique patient case can be the basis for negotiating with a specialist. For example, Grace says he may feel comfortable being an attending once certain conditions are met (e.g., once the specialist has seen the patient in situations in which there is a question about whether a surgical intervention is needed).

Further, Grace says that if he knows he can count on receiving backup support from the specialist, he is more willing to take role the of attending. Grace adds that his decision to accept the role of attending also takes into account his personal assessment of how soon the patient must be seen by the specialist. For example, he asks, can the patient wait until first thing in the morning, and will this specialist be there to see the patient at that time?

4. Expect to provide and receive backup. Specialists may not get everything they need from hospitalists, but hospitalists can remind specialists of the extent to which they lighten their load, Grace says. “We may not get them to 100% of where they want to be, but we can get them a great deal closer than their present situation,” Grace says.

Grace points out that the hospitalist can relieve the specialist of paperwork, provide assistance by dictating discharge summaries, arrange postdischarge appointments, and “cross the t’s and dot the i’s.” The hospitalist can assume care of a trauma patient “once the bones are pinned and the head is fixed and the patient is out of the coma,” he says. The hospitalist may need to have the gastroenterologist come to the hospital in the middle of the night for a patient who is bleeding profusely, but not for a patient who is bleeding from a slowly progressive anemia, Grace says.

In a worst-case scenario—when the hospitalist has spoken to the specialist about the patient but he or she has refused to see the patient or be involved in his or her care—Grace and Simone advise hospitalists to include this information in the patient record.

5. Seek expert opinion when necessary. Koser says it is the specialist who has the ultimate authority to make statements to the patient and the patient’s family about prognosis and treatment. He provides the following example: If a patient has an intracranial hemorrhage that may lead to death or disability, the family “wants to hear from an authority that nothing can be done.”

Grace says he often points out to specialists that patients are not transferred so they can receive the same level of care, but rather so they can receive a higher level of care (e.g., a neurological evaluation, not another medical evaluation).

Koser notes that it is not always just the patient’s condition and the negotiations between the specialist and hospitalist that determine who should be the attending physician. For example, a factor that can influence the decision of which physician should be the attending is whether a hospital medicine program is devoted to maintaining a short average length of stay (LOS) for patients.

In such cases, the hospitalist program may be willing to admit a patient with a gastrointestinal bleed who is expected to have a short LOS, but not a patient with a chronic condition. ■
NY and CA pass laws on billing uninsured

New rules guide hospitalists in developing their own policies

Hospitals nationwide have been under attack for the way in which they bill and collect debts from uninsured patients, especially the practice of billing uninsured patients at rates that are higher than the negotiated rates paid by top insurance companies.

To combat these practices, the states of New York and California have passed legislation that establishes rules for how hospitals can bill their uninsured patients. New York’s law was passed as part of the previous state budget, and California’s legislation, AB 774, was passed by both the Senate and the Assembly and recently signed by the governor, who vetoed similar legislation a few years ago.

With many hospitals now reviewing their own policies on charity care and billing, the two states’ laws serve as models for discount policies and payment collection. And although hospital medicine groups bill separately than hospitals, they also may want to consider these models as guides in developing their own policies for billing the uninsured.

Income guidelines set

California and New York will require hospitals to offer discounts and financial assistance or charity care to uninsured patients or patients with high medical costs who have incomes of up to 300%–350% of the federal poverty level (FPL). The laws also require hospitals to have clear, stated policies about charity care, as well as establish discount payments and disclose them to the public. New York and California also limit hospitals’ debt collection practices.

“With legislators, there’s a real sense of unfairness that those who have the least ability to pay, pay the largest amount,” says Kala Ladenheim, PhD, a program manager for the National Conference of State Legislatures’ Forum for State Health Policy Leadership.

Both states’ laws will require that uninsured patients’ charges, before discounts, must be no higher than the negotiated rates paid by the highest payer or by a government program.

Disclosing policies

Hospital charity care policies are a “well-kept secret,” says Cathy Levine, executive director of the consumer activist group Universal Health Care Action Network of Ohio. Many consumers who might qualify for financial assistance are unaware of the policies. Some hospitals don’t even have written and standard policies and say they evaluate situations on a case-by-case basis, she says. “[Using a] case-by-case basis isn’t good enough. There’s no fairness there; it becomes subjective.”

Hospitals would be better off putting their time and effort into screening uninsured patients for their eligibility for public insurance programs, rather than in billing and collecting, she adds.

“A patient who has just given birth in your hospital is an obvious candidate for Medicaid or, if she’s an immigrant, for the Alien Emergency Medical Assistance program, which is a Medicaid program that provides full medical coverage for emergency medical conditions for non-U.S. citizens, Levine says. However, many hospital billers seem surprisingly unaware of government programs that already exist to cover low-income patients, she adds.

California legislation

California’s new law will require hospitals to “make all reasonable efforts” to obtain information from patients about whether they are covered under Medicare, Medicaid, or other government programs. If the patient is not covered, the hospital must inform the patient of those programs and provide...
Billing laws  p. 7

him or her with applications to them at discharge. If approved by the governor, the new law would also require that hospitals
- have an “understandable written policy” on charity care and offer financial discounts to uninsured patients who have incomes at or below 350% of the FPL
- disclose their billing policy to patients and post notices about it in public areas (e.g., the emergency department, billing office, admission offices, waiting areas, etc.)
- charge uninsured patients no more than the rate paid by Medicare, Medi-Cal, Healthy Families, or other government programs for the same services, whichever rate is greater
- exclude the following when determining patients’ eligibility:
  – Retirement or deferred-compensation plans
  – The first $10,000 of a patient’s monetary assets
  – 50% of monetary assets over the first $10,000
- establish written policies for debt collection

Under the California law, hospitals or agents collecting debt would be unable to garnish a patient’s wages or conduct a sale of the patient’s primary residence. For patients who are in “good faith” and who attempt to pay bills on a payment plan, the hospital or its agent may not put liens on a primary residence, charge interest, or report the patient to a consumer credit reporting agency.

The California Hospital Association (CHA) took a neutral position on the legislation, explains Jan Emerson, vice president of external affairs for the association. The CHA had opposed the legislation when it included consumers with incomes of up to 400% of the FPL (very early drafts of the legislation called for assistance for those with incomes of up to 700% of FPL, she says). The CHA withdrew its opposition after income guidelines for discounts were lowered to 350% of the FPL and language was included in the legislation that put responsibility on consumers to communicate with hospitals.

Consumers who earn 400% of the FPL “should be carrying insurance,” Emerson says. The law also covers the “underinsured” (e.g., consumers who use health savings accounts), she notes. Although Emerson says hospitals should be more proactive in making their policies known to the public, she adds, “On the flip side, the public has to do a better job of communicating with the hospital.” In many of the debt-collection horror stories that have been publicized by the media, she says consumers may not have been responding to hospitals’ letters and calls.

James Packer, Esq., general counsel for HRA Medical Management, Inc., in San Diego, which provides billing and collection services for hospitalist groups, says hospitalists generally follow their own policies in billing and collecting from uninsured patients, although some hospitals could ask their hospitalist groups to follow the hospital policy. The language in the California legislation does not mention physicians, but because legislation may have unintended

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<th>Hospitals post charity care policies on Web sites</th>
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<td>Some hospitals are now making it a practice to post their charity care policies on their Web sites. The policies offer discounts to consumers who have incomes of up to 500% of the federal poverty level (FPL) and provide detailed information to consumers about their options for payment assistance with hospital bills. The following are examples of links to two hospitals’ policies:</td>
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<td><strong>Thomas Jefferson University Hospital</strong> in Philadelphia offers discounts to consumers who have incomes of up to 500% of the FPL (<a href="http://www.jeffersonhospital.org/rx_files/patient/charity_care10279.pdf">www.jeffersonhospital.org/rx_files/patient/charity_care10279.pdf</a>).</td>
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<td><strong>Providence Health Systems</strong> in Washington has posted a detailed charity care policy on its Web site. Before determining eligibility for its own charity care program, the system first determines whether a patient is eligible for other insurance programs (<a href="http://www.providence.org/washington/billing/Charity.htm">www.providence.org/washington/billing/Charity.htm</a>).</td>
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consequences, California physicians would be wise to lobby for confirmation that it does not apply to them to avoid a government mandate, Packer says. In some cases, uninsured does not mean that the patient does not have the ability to pay, he notes.

New York law
In New York, the new state law targets patients with slightly lower household incomes (at and below 300% of the FPL). Eligible patients will be charged the same rates as the hospital’s highest payer and will receive a discount based on their income category. Patients under 100% of the FPL will pay only a “nominal amount,” patients between 100% and 150% will pay no more than 20% of the rate paid by the highest payer, and patients from 150% to 300% of the FPL will pay an increasing percentage of charges based on a sliding fee scale.

The New York law also requires that hospitals
- have clear, understandable polices that are made available to the public
- allow for monthly payment plans that amount to no more than 10% of the patient’s gross monthly income
- enable patients to apply for assistance within 90 days of discharge and render decisions on the applications within 30 days
- advise patients 30 days in advance of referring them to a collection agency

As a requirement of a hospital’s participation in the charity care pool, the hospital will have to report the amount of the charity care it has provided and not collected, the number of patients who applied for financial assistance and the number who were denied, and the number of liens placed on properties. The law is referred to as Manny’s Law, named after a 24-year-old who died in 2004 from a ruptured blood vessel related to a congenital defect known as arteriovenous malformation, or AVM. Surgery at a New York City hospital was allegedly delayed while the hospital waited for approval of his Medicaid application.

Restrictions on debt collection
Washington was one of the first states to pass a law on billing the uninsured, requiring that hospitals provide free care to those below 100% of the FPL and discounted care to those below 200%, says Ladenheim.

Connecticut passed Public Act 03-266 in 2003, which strengthens requirements for hospitals to disclose the availability of free care. Hospital billing and collection agents have to include notices of charity programs in their collection notices. The Connecticut law requires that the hospital make an effort to find out about the consumer’s ability to pay before filing a lawsuit and that the collector cease collection efforts if the debtor qualifies for charity care.

An earlier but little-known Connecticut law (Public Act 03-266) prohibited hospitals from collecting more than the cost of providing care from any uninsured patient whose income is below 200% the FPL, according to an analysis of state laws and policies on hospital billing by Families USA.

Last year, the Minnesota Attorney General’s Office forged agreements with five leading hospitals in the state on debt collection from uninsured patients. The agreements provide that patients with household incomes of $125,000 or less will not pay any more than the rates paid by the highest payer.

Hospitals and clinics agreed that before submitting patients’ names to a debt collector, they would make sure that any insurance company that may be responsible to pay the claim has been billed, that the patient has been offered a payment plan, and that the patient has been offered any free or discounted care for which he or she may be eligible under the hospital’s charity care policy. The agreement covers more than 50% of the beds in the state.

For states’ attorney generals, the issue of whether nonprofit hospitals are providing enough charity care is a cyclical issue that seems to surface every seven to 10 years, Ladenheim says.

The CHA promoted the use of voluntary guidelines for the industry in 2004. Later that year, the Health Access Foundation visited 40 of California’s
Recruiting tip of the month: Checking references

Although many healthcare organizations leave their reference checks until the end of the recruiting process, these checks may be among the most critical steps in hiring new physicians.

Reference letters from candidates provide helpful insights, but they do not replace the need for in-depth telephone conferences with at least three sources who have knowledge of the candidate’s past clinical experience.

Consulting references early in the recruiting process is valuable not only because these individuals can alert you to potential trouble spots, but also because they enrich the interview process and help you better understand the candidate’s prior clinical and workplace experiences.

Not all references are alike

Ideally, the references you interview should have recent experience with the candidate and have known him or her for at least one year in a professional capacity.

Once you’ve introduced yourself to the reference, give him or her only a brief description of the position for which the physician is applying. A “behavioral” interviewing style is effective when querying references. Try asking open-ended questions, such as the following:

- Can you please briefly describe the candidate’s style and approach to making clinical decisions?
- What types of office or practice environments and cultures would be the most appropriate for this physician to excel?
- Please share any insight as to how the candidate comes across to patients.
- Would you feel comfortable having this physician treat a member of your family? Why, or why not?

Next, ask the reference to describe a particular situation in which the candidate exhibited certain qualities or behaviors. While checking references, you may learn negative information about a candidate that may influence your opinion of him or her. However, do not share this information with others, including the candidate. Doing so violates the confidentiality of what the reference has shared. Sharing such information could also limit the effectiveness of securing candid assessments from this reference in the future.

Follow the rule of securing references before you interview, and you will increase your ability to assess the hospitalist’s viability as a candidate and as a good fit for your team.

Editor’s note: This month’s tip was submitted by Paul Smallwood, vice president of physician search at St. Louis–based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.
Study: Data mixed on value of ped hospitalist programs

Pediatric hospitalist programs decrease patients’ length of stay (LOS) and hospital costs, but most programs are breakeven or fail to cover the cost of the program, according to a team of researchers that conducted a systematic review of 20 studies of pediatric hospitalist programs. The researchers, who published their results in a recent issue of Pediatrics, selected the 20 studies from a pool of 47 published studies to assess the effect of pediatric hospitalists on the following factors:

- LOS
- costs
- quality of care
- patient experience of care
- provider satisfaction
- house staff educational experience

Systematic reviews of existing literature have been done for adult pediatric hospitalist programs, but not for pediatric hospitalist programs, the researchers say. In general, a pediatric hospitalist program saves 0.3 LOS days and several hundred dollars per patient. “Multiplication of such a decrease by 1,000 general pediatric inpatients per year (a typical annual cen sus for an inpatient pediatrics service) yields an annual cost savings to the healthcare system of several hundred thousand dollars,” the researchers state. But in a survey of 40 hospitals, only 11% reported making money, whereas 39% lost money and the rest broke even.

In six of seven studies on pediatric hospitalist programs, LOS decreased by 4%–16% and costs decreased by an average of 6%–15% when pediatric hospitalists managed patients as compared to when pediatricians managed patients. Only one study of 722 children admitted with bronchiolitis and asthma (462 in the hospitalist group, 260 in the comparison group) failed to show decreases in LOS and costs.

Parent and PCP satisfaction

Pediatricians gave hospitalists favorable ratings in five out of five studies. In fact, they were more likely to view hospitalists as beneficial or neutral to quality of care than internists. In one study of 654 pediatricians, only 20% said that limiting inpatient involvement diminished career satisfaction, whereas 53% said that attending on inpatients takes too much time away from the office.

Parents rated pediatric hospitalists as more courteous in one study based on surveys of 190 parents, but there was no difference between ratings of hospitalists and primary care physicians (PCP) on five other measures of satisfaction. In another study of 377 parents in a Boston health maintenance organization, overall ratings of care improved after the implementation of a hospitalist program.

Quality of care data lacking

Limited data have been collected on quality of care in pediatric hospitalist programs. One study of 1,211 patients at University Hospital in San Antonio found a decreased mortality rate in the pediatric intensive care unit when hospitalists, as opposed to residents, provided after-hours care. However, another study found that readmission rates were higher for hospitalists. Notably, the researchers stated that this finding has not been replicated, and that the numbers of patients in readmission rate studies are too small to detect differences in readmission rates.

The researchers say a new initiative called Pediatric Research in Inpatient Settings (PRIS) will help fill the gap of large multicenter studies that evaluate therapies in inpatient pediatrics. More than 80 hospitals and 200 hospitalists are participating in early research that includes studies on asthma, jaundice, prevention of allergic disease in newborns, and medical decision-making by families of children with life-limiting diseases. The American Academy of Pediatrics, the Ambulatory Pediatrics Association, and the Society of Hospital Medicine have worked together to form the PRIS network.

Sources: Patrick H. Conway, MD; Sarah Edwards, BA; Christopher P. Landrigan, MD, MPH; Rajendu Srivastava, MD, FRCP, MPH. “Pediatric Hospitalists: A Systematic Review of the Literature,” Pediatrics, 2006, 117; 1736-1744.
In the news

CMS proposal could increase pay to hospitalists

The Centers for Medicare and Medicaid Services (CMS) has proposed changes to its physician fee schedule that could significantly increase payments for the care and services (e.g., hospital visits, consultations, etc.) that hospitalists provide to Medicare beneficiaries.

Many health plans nationwide have adopted CMS’ relative value units (RVU) for their own fee schedules. If the proposal becomes a reality as it is currently written—which means that the changes would take effect in January 2007—it is likely that hospitalists would see the payment increases. However, CMS could modify the proposal before then based on recommendations from Congress and other relevant parties.

As a result, the Society of Hospital Medicine (SHM), in a letter dated September 19, encouraged its members to write Congress in an effort to stop a possible 5.1% reduction to work RVUs in the 2007 Medicare physician update.

SHM’s letter states that “Medicare’s flawed Sustainable Growth Rate formula, which cuts physician payments whenever increases in these expenditures outpace increases in the Gross Domestic Product, will trigger the cut on January 1, 2007, unless Congress acts.”

As of the print date for this newsletter, CMS had not yet made its final decision.

Editor’s note: To access SHM’s advocacy Web page, go to www.hospitalmedicine.org.

Questions? Comments? Ideas?

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