Hospitalists on the front line for identifying palliative care patients

Regions Hospital in St. Paul, MN, is one of a growing number of hospitals that offer palliative care services to their most seriously ill patients, but one of only a few that have a hospitalist-led service.

Making the case for a palliative care service is not unlike making the case for a hospital medicine program, says Howard Epstein, MD, hospitalist and medical director of the Palliative Care Program at Regions. Currently, five hospitalists at Regions—all of whom are in the process of getting board-certified in hospice and palliative medicine—provide palliative care services to patients along with a full-time nurse practitioner, a half-time chaplain, and a half-time social worker.

To get approval for the service, Epstein says he spent a year and a half conducting both a needs assessment and resources assessment, researching other programs, and developing a business plan to win administrative support and funding.

Like many hospital medicine programs, palliative care...
services are not self-supporting solely from revenue production but reap other benefits for the hospital, Epstein says. They can reduce length of stay, reduce the use of the intensive care unit, and make more beds available for hospitals that are running at or near capacity. For patients receiving palliative care, there is also a dramatic reduction—as much as 50%—in variable costs for services such as radiology, pharmacy, and surgical procedures, Epstein says.

Approach to care for high-need patients
Palliative medicine is the treatment of patients who have life threatening or severe advanced illness. These patients are expected to continue to progress toward death, and their care is focused on alleviating suffering and promoting quality of life.

“Palliative care programs provide a systematic approach to care for ‘outliers,’ patients with the highest intensity needs within an inpatient population,” according to the guide Building a Program, published by the Center to Advance Palliative Care in New York City. The guide stresses that an important component of making the financial case for a program is explicitly stating that palliative care can contribute to hospital revenues through its effects on hospital capacity.

Often, the physician who attempts to build and sell a palliative care program is new to the hospital, says Epstein. At Regions, the program was built from within. Hospitalists were identified as good candidates for the palliative care service if they were good listeners, excelled at conducting family conferences, and were highly regarded by their peers, Epstein says. Whereas a new physician starting a program would have to develop a rapport with staff to get consults to the service, these hospitalists had already done so.

“They were known commodities to oncologists, intensivists, and nephrologists,” he says. At Regions, hospitalists on average work one week each month on acute care and two weeks each month on palliative care, with one week off, Epstein says. He notes that having a hospitalist’s entire day dedicated to palliative care has worked better than splitting the day between acute and palliative care services. Splitting time during the day was frustrating for hospitalists, because acute care often took over the day and they would end up spending only 10% of their time on palliative care, he adds.

Training needs
To participate in the palliative care program, all of the hospitalists at Regions must complete the Education for Physicians on End-of-Life Care (EPEC) Project curriculum (available online at www.epec.net). The EPEC Project was developed at the Northwestern University Feinberg School of Medicine in Chicago. The palliative care hospitalists also agreed to obtain additional training and work toward board certification in hospice and palliative medicine. This certification was recently approved by the American Board of Medical Specialties as a recognized subspecialty within several fields of medicine.

Although palliative care is one of the core competencies of hospital medicine identified by the Society of Hospital Medicine (SHM), many hospitalists do not feel that they are adequately trained in it, according to Epstein. During its May meeting in Dallas, SHM will offer a clinical track dedicated to palliative medicine with five breakout sessions covering basic pain management, nonpain symptom management (e.g., anxiety, nausea, constipation, etc.), how to conduct care conferences, communicating bad news (see “Six steps to help break bad news to patients” on p. 5 for more on this topic), ethical and legal issues in palliative medicine, and prognostication.

Prognostication challenges
In addition to communication challenges, prognostication is a major challenge for hospitalists recommending palliative care to patients, Epstein says. Prognostication is especially challenging for patients who are in end-stage organ failure, he says. When patients ask how long they have to live, it is hard for a physician to tell whether they will die during the current admission or live for another three years.
with frequent exacerbations of their disease and repeated hospitalizations, Epstein says.

New palliative care guidelines soon to be released by the Institute for Clinical Systems Improvement will help hospitalists and other physicians better determine which patients are suitable candidates for palliative care and when to initiate a discussion about palliative care with a patient and his or her family, Epstein says.

When patients are in and out of the hospital, it can be difficult for them to accept that their disease is terminal because they have already left the hospital on previous admissions in improved condition. A poor prognosis is often more apparent to both patients and their physicians and more readily accepted when the patient has metastatic cancer or a devastating acute illness (e.g., severe intracranial hemorrhage). However, guidelines will help hospitalists better assess a patient’s health trajectory, says Epstein.

**Denial a strong mechanism**

It can be hard to get patients and family members to acknowledge the need for palliative care. “Denial is a strong and helpful mechanism,” says Lyn Ceronsky, APRN, MS, system director of the Palliative Care Leadership Center at Fairview Health Services in Minneapolis. This is the case not only for patients, but also for family members.

When an 85-year-old parent has survived several health crises, it can be difficult for some family members to believe that another crisis is life-threatening, she says. “The psyche has to catch up with the fact that two months ago, Dad was out golfing, but now he is not going to be better.”

Hospitalists are well-positioned to make referrals to palliative care, says Ceronsky. “Any physician who is in the hospital 24/7 is likely to become aware of palliative care needs in a more timely way.” However, deciding who needs palliative care is an inexact science. “Hospitals are very treatment-care oriented,” she adds. “Doctors don’t have good tools to recognize when a patient is an appropriate candidate for palliative care. There is no blood test or x-ray that can tell you that.” Guidelines for palliative care will give physicians more concrete tools for assessing patients, she says.

Recent research by the Robert Wood Johnson Foundation’s California Hospital Initiative in Palliative Services project suggest that the presence of hospitalists is positively correlated with success in establishing a palliative care service, regardless of whether the hospitalists were actively involved in the program’s development.

**Programs are multifaceted**

Good palliative programs address the

---

**End-of-life project trains hospitalists in palliative care**

To supplement their training in palliative care, hospitalists at Regions Hospital in St. Paul, MN, use the end-of-life curriculum offered by the Education and End-of-Life Care Project at the Northwestern University Feinberg School of Medicine in Chicago. The curriculum, available online at [www.epec.net](http://www.epec.net), consists of the following modules:

- Gaps in end-of-life care
- Legal issues related to palliative care
- Elements and models of palliative care
- Pain management: Analgesic/opioid dosing guidelines
- Pain management: Equianalgesic dosing guidelines
- Pain management: Managing specific pains/adverse effects
- Communicating bad news
- Advance care planning
- Physician-assisted suicide/euthanasia
- Whole patient assessment
- Negotiating goals of care
- Managing sudden, critical illness
- Medical futility and conflict resolution
- Withholding/withdrawing therapy
- Common physical symptoms
- Depression, anxiety, and delirium
- Last hours of living

---

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at [www.copyright.com](http://www.copyright.com) or 978/750-8400.
Palliative care management of the physical, psychological, social, and spiritual needs of patients and their families. Communicating with patients and families on a more spiritual level can sometimes lead to a breakthrough in making decisions about palliative care, Ceronsky says. The involvement of a chaplain in many palliative care programs can bring the discussion to that sphere.

Similar to hospice programs, palliative care addresses different spheres of suffering, including psychosocial, financial, spiritual, and existential, explains Epstein.

“It takes the same team-based, patient- and family-centered approach, but moves the process further upstream in the patient’s course of illness,” he says.

How to make the case for a palliative care program

If your hospital is thinking about establishing a palliative care program, you can help sell the idea by making hospital leaders aware of the myriad benefits. A palliative care program benefits not only patients and families, but also can have a positive effect on hospital staff, the community’s primary care physicians, and the hospital’s own operations, according to the Center to Advance Palliative Care (CAPC).

Like hospital medicine programs, palliative care programs do not support themselves and must demonstrate their benefits to the hospital. Some of the key advantages outlined in the CAPC’s Building a Program guide include

- **lower costs for hospitals and payers.** A hospital can develop a palliative care program with a low start-up investment but have an immediate effect on “outlier cases,” overall resource use, and use of the intensive care unit (ICU). With palliative care, patients are transitioned to appropriate levels of care, which reduces length of stay, especially in the ICU, and reduces the use of unnecessary or ineffective tests and pharmaceuticals.

- **support for primary care physicians.** Palliative care teams save physicians time by helping with care coordination and working with patients and families on the goals of care. They provide expertise in pain and symptom management and help coordinate the treating physician’s orders, including discharge planning.

- **increased patient and family satisfaction.** Patients who receive palliative care have a high level of satisfaction with their physicians, healthcare team, and hospital. The programs also increase family satisfaction with hospital services and build loyalty to the institution.

- **meeting Joint Commission accreditation standards.** Palliative care programs help hospitals meet pain and other quality standards developed by The Joint Commission. A major goal of palliative care is to manage uncontrolled symptoms and control pain.

- **increased staff retention and satisfaction.** Palliative care programs help hospital staff provide highly coordinated care for their patients, thus increasing staff job satisfaction and retention. Programs assist staff by providing patient/family case management and coordination, ensuring effective management of complex and changing symptoms, and providing high-quality bedside care to patients.

- **meeting the needs of an aging population.** Palliative care can help the hospital meet the needs of an aging population with multiple chronic illnesses. Many people will live for years with heart and lung disease, diabetes, cancer, and Alzheimer’s disease. A palliative care program provides continuity of care and coordination through episodic and long-term illnesses. Although elderly patients want to stay as independent and healthy as possible, a palliative care program provides practical support and helps them make decisions about the most appropriate level of care.

Six steps to help break bad news to patients

A constant challenge for hospitalists—and most physicians—is how to break bad news to a patient.

When breaking bad news to patients, it’s important to ask what they know about their conditions and what they want to know, says Robert Buckman, MD, a medical oncologist at the Princess Margaret Hospital in Toronto, ON, and a professor in the department of medicine at the University of Toronto.

Buckman is the author of How to Break Bad News: A Guide for Health Care Professionals, a book on communicating with patients that has been widely adapted and is often used to teach physicians how to be better communicators.

Buckman says that at the time he wrote the book, which was published in 1992, he had just read a study conducted in London that found that only 50% of lung cancer patients wanted to know about their diagnosis. He says finding out how much a patient wants to know is a key but easy-to-neglect step in the six-step process he developed for breaking bad news to patients.

The process, known as S-P-I-K-E-S, stands for:

- **Setting**—providing a private setting for the patient and significant others
- **Perception**—determining what the patient knows before giving the news
- **Invitation**—finding out how much the patient wants to know
- **Knowledge**—sharing the news in small blocks of information
- **Empathy**—taking the time to respond to patients feelings as they hear the news
- **Strategy and summary**—communicating a plan of action

**Questions physicians can ask**

To ascertain what the patient perceives about his or her condition, ask questions such as the following:

- What have other physicians told you about your condition?
- What do you understand about your illness?
- When you first had symptom X, what did you think it might be?

To find out how much information the patient wants, ask questions such as the following:

- Should I tell you the full details of your condition?
- If not, is there somebody else I should talk to?
- Do you prefer to know all of the details about what is going on or would you prefer that I just tell you about treatments I am proposing?

**How to convey the information**

It’s important to give the patient information in small blocks and to give him or her time to absorb the information and respond to it, Buckman says. After the preparatory steps of perception and invitation, give the patient an indication or warning that there is bad news to come, says Buckman.

Make sure that the patient comprehends what you are saying, he adds. Ask the patient, “Do you follow me?” or, “Am I making sense?” However, be careful about saying “I’m sorry,” he says. “I’m sorry” has two meanings—one meaning is “I feel sorry for you,” and another is “I’m sorry I did this.” Aside from implicating that you are somehow responsible for the patient’s condition, “I’m sorry” also acknowledges your emotions rather than your patient’s emotions.

Buckman says he prefers to use “wish statements.” Examples of wish statements include, “I wish things were different” or “I wish the disease wasn’t progressing with treatment.”

**What to say about a prognosis**

Physicians often dread being asked prognosis questions by patients, but they can’t pretend the question doesn’t exist, Buckman says. Always give a ballpark range. Never say a patient has three months or six months to live, because it is impossible for you to know with certainty, he says.

For more information, go to Buckman’s Web site at www.drbuckman.com.
Battling bias  < p. 1

physicians who were trained as internists. According to the most recent Society of Hospital Medicine (SHM) survey, 75% of hospitalists were trained as internists, 11% were trained in pediatrics, and 3% were trained in FP.

Task force examines bias
Gundersen now heads an SHM task force on FP physicians in hospital medicine. The task force will look at both increasing the number of FPs in the field and at maintaining the viability of FP-trained hospitalists already in the field, he says.

The task force grew out of a special-interest focus group conducted at an annual SHM meeting where many of the FP-trained hospitalists in attendance shared their experiences.

“The real concern among us is that if you were trained in [FP] you are not treated as an equal to the internal medicine–trained hospitalists in many parts of the world,” Gundersen says.

The goals of the task force are to prove that the bias is there, examine why it exists, and educate physicians and others in the field to dispel the bias, he says.

To document that a bias exists, Gundersen says the SHM included a question about hiring FP-trained hospitalists in a recent short survey.

The survey asked hospitalist leaders whether they would hire an FP-trained physician.

“The numbers were not great,” says Gundersen. Half of respondents said they were not inclined to hire a hospitalist trained as an FP.

Current competence
The problem is that those trained in FP medicine need to demonstrate that they are equally as competent to do the job.

“It’s all about competence,” says Carol Cairns, CPMSM, CPCS, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Cairns works with hospitals around the country on credentialing and privileging issues. “Can you show that you have equivalent competence to others who have the privileges?” she says.

“It doesn’t matter if it’s [an FP] or an internist,” she adds. “Like an FP, the internist might have been office-based for years.”

When credentialing and granting privileges to hospitalists, a medical staff office would want to see relevant work experience and training in managing patients in an acute-care setting that are similar to the type of patients who would be managed in the hospitalist position, Cairns says.

A different path
Gundersen points out that in Canada, most hospitalists have an FP background. He says he thinks of himself as a hospitalist, not an FP. “We just came to the field in a slightly different manner,” he adds.

Gundersen acknowledges that because there is currently more of a focus on training FPs in ambulatory settings, newer physicians may not typically have enough hospital-based training for hospital medicine.

However, he stresses that it’s important to evaluate each candidate on a case-by-case basis and judge him or her on individual experience, training, and demonstrated commitment to the field of hospital medicine.

He also is concerned that FPs will be shut out of the field as a result of efforts to set up a certification process for hospital medicine.

The SHM has been working with the American Board of Internal Medicine (ABIM) on such a process, but Gundersen says he is in favor of an independent certification process for hospitalists, rather than placing it under the individual umbrellas of the ABIM, the American Board of Family Practice, or the American Board of Pediatrics.
Hospitals use carrots, sticks, and other strategies to manage the on-call specialist shortage

The shortage of on-call specialists can result in delays in admitting emergency department (ED) patients to the hospital if they require specialist care, create uncertainty and stress over who will provide specialized care for the patient, and lead to conflicts with specialists over the need for timely care when the patient is admitted or needs care late at night or on weekends. Hospitalists are on the front lines of this crisis.

In a recent Society of Hospital Medicine survey, 11% of hospital medicine leaders said specialist availability for consultation is one of their top 10 concerns. Although a complete solution to the ED coverage problem is a long way off for many organizations, there are steps that hospitalists can take to improve the process. In fact, some hospitals have turned to their surgical hospitalists or laborists to address the shortfall in specialist care, which shows that the hospitalist movement continues to evolve.

In December 2006, the American Health Lawyers Association (AHLA) and HCPro, Inc., the publisher of this newsletter, held two separate audioconferences that explored some of the latest strategies for better managing the on-call specialist problem.

An unsolvable problem
The on-call specialist shortage is essentially an unsolvable problem, said Richard Sheff, MD, chair and executive director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Sheff spoke during the December 20 HCPro-sponsored audioconference “Designing a Strategy for ED On-call: Effective solutions for physicians and hospitals.”

The problem is unsolvable because of the many factors and dynamics that come into play on the issue, including the misdistribution of specialists, the trend of physicians putting a higher priority on family and lifestyle, the growth of the uninsured population, and the diminishing importance of the hospital in the private practices of many physicians. Rather than strive to solve the problem, a wiser strategy for hospitals is to manage the problem in the best way possible by recognizing and identifying the tensions and competing interests of physicians, hospitals, and the community, Sheff said.

Keep in mind that the hospital’s success managing the problem depends on how fair physicians perceive the approach to the crisis. Conflicts over the ED on-call specialist issue are essentially about how communities, physicians, and hospitals will equally share the pain of providing this coverage, he said.

The role of EMTALA
The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed in 1986 to control patient dumping by hospitals and “wallet biopsies,” or screening patients for their ability to pay, said Todd Sagin, MD, JD, vice president and national medical director of The Greeley Company, who also spoke during the HCPro audioconference. However, EMTALA has contributed to the shortage of ED on-call specialists because it places the responsibility for EMTALA compliance directly on hospitals and not on physicians, Sagin said.

Under EMTALA, hospitals must

- provide an appropriate medical screening exam
- stabilize patients
- maintain an on-call physician list
- ensure that on-call physicians respond in a timely manner

“The heart of contention between hospitals and physicians is that physicians are not required to be on-call unless they are on the ED on-call list,” Sagin said. In the past, the demands of ED coverage were considered the shared responsibility of hospitals and physicians, but that’s no longer the case, he said.

“There’s a shrinking core of providers taking care of patients in the hospital,” Sheff added. Shortages of specialists are common in plastic surgery; ear,
nose, and throat: and ophthalmology. Under EMTALA, a hospital must provide coverage in the ED for those specialties that it provides on an inpatient basis if it is reasonable to do so given its resources, medical staff, location, and other local factors.

Despite the seemingly onerous EMTALA requirements, the government hasn’t been onerous in the enforcement of law, according to Sagin. He explained that the Centers for Medicare & Medicaid Services (CMS) conducts approximately 400 EMTALA investigations per year, but has sent only a few cases to the Office of Inspector General that have resulted in fines.

Note: EMTALA violation fines can be as high as $100,000 per incident for the hospital or $50,000 for a nonresponsive physician. CMS can also exclude the providers from Medicare and other government programs.

Attempts to avoid on-call duty
Although taking ED call was once seen as a good way for physicians to build their practices, physicians are now less interested in being available to the hospital at all hours, Sheff said.

Sheff says some specialists try to avoid ED call duty by limiting their hospital privileges to avoid treating conditions that are common in EDs and claiming that they do not have “current competence” to care for patients with such conditions.

Because EMTALA requires only that hospitals screen and stabilize ED patients, one way to avoid the “privileging shuffle” that physicians use to get out of ED call is to tell specialists that they do not need to definitively treat the patient, but only need to assess, stabilize, and ensure the appropriate disposition of the patient, Sheff said.

However, hospitals could threaten physicians with an EMTALA violation if they are found to be selectively available to patients, Sagin said. In other words, physicians could be found in violation if they are unavailable for some patients, but have been “historically willing to see their own patients or patients referred by other physicians,” he said.

Tip: Hospitals may want to consider adopting core privileges for specialties, which can improve communications about what is expected of a specialist and what procedures require additional training, Sheff said. Such a privileging system will hinder the specialists’ ability to limit his or her ED on-call responsibilities.

Specialties that hospitals most likely compensate for on-call duty

General surgeons, orthopedic surgeons, and neurosurgeons are more likely to receive compensation for taking emergency department (ED) on-call than other specialists, according to a survey of emergency department directors conducted by the American College of Emergency Physicians (ACEP) in 2005.

The survey asked ED directors, “Does your hospital pay stipends to any specialist physicians for providing on-call coverage? Which specialties?” It defined stipends as fees received for being on call even if the physician sees no patients. The following is a breakdown by specialty of the percentage of responding hospitals that pay for on-call duty:

- General surgery 25%
- Orthopedics 20%
- Neurosurgery 16%
- Obstetrics/gynecology 12%
- Ear, nose, and throat 7%
- Ophthalmology 6%
- Plastic surgery 6%
- Psychiatry 6%
- Hand surgery 5%
- Vascular surgery 4%
- Gastroenterology 4%

Source: On-Call Specialist Coverage in U.S. Emergency Departments, ACEP. Published April 2006.
Compensation for on-call duties
To meet their EMTALA obligations, some hospitals have resorted to paying specialists $1,000–$3,000 per night to take call, said Sheff.

However, when establishing compensation for specialists, experts say, it is important to be careful when negotiating fees because of Stark and anti-kickback laws that make it illegal for providers to accept payment for generating Medicare, Medicaid, or other federal healthcare program business.

When a hospital responds to a specialist’s demand for on-call compensation it could raise questions about kickbacks, especially if the payments are not for specific services rendered, Sagin said.

For a nonprofit hospital, fees to physicians that are above fair market value may jeopardize tax-exempt status because of the prohibitions in federal tax laws against private inurement, Sagin said.

The fees could be interpreted as an effort to retain patient referrals. Therefore, hospitals should be careful of the “wording and language in trying to negotiate some of these arrangements,” Sagin advised.

Hospitals that want to supplement payments for ED call also must be careful to comply with Medicaid’s antisupplementation rules that require participating providers to accept Medicaid payment in full for services furnished to a recipient, said David Weil, vice president and chief legal officer for the East Florida Division of HCA, Inc., in Nashville, TN.

Weil spoke during the December 12 AHLA audio-conference “Approaches to Ensuring ED Call Coverage: What’s Working, What's Not, and What's on the Horizon.” It’s important to be clear that payment is not made with intent to supplement Medicaid.

There is no safe harbor for on-call compensation, said Scott Safriet, a principal with HealthCare Appraisers, Inc., in Delray Beach, FL, during the AHLA audioconference. Setting a fair market value with a third party is often the best way to avoid regulatory problems on the kickback issue, he said.

When helping a hospital set compensation for specialists, Safriet said he examines compensation values from published surveys; hospital and medical associations; local, regional, or national market values; and independent appraisers. But other factors also are taken into account in setting compensation, including
- the frequency and nature of call events. For example, is the physician required to be present in the ED? What is the required response time? Are phone consults provided?
- the nature of the specialty.
- the number of physicians available to participate in call rotation.
- exposure to unfunded care (uninsured and Medicaid patients).

For discount bulk rates, call toll-free at 888/209-6554.
On-call specialists

- professional liability exposure.
- in-kind compensation (e.g., reimbursement for continuing medical education).

**Tip:** Two nearby hospitals may have very different characteristics, Safriet said, so finding out what a competing hospital pays for on-call services may not be that useful and applicable. He warned that physician-reported values may be incorrect and unreliable.

**Importance of fairness**

Sheff recommended trying to reach an agreement with specialists about what level of unreimbursed on-call coverage they think is fair.

Depending on the burden of call, the group might agree that one to six nights of coverage per month is fair. If there are 15 specialists, the hospital might have full coverage based on an agreement that two days per week is fair. If a group of specialists believed that two nights per month of reimbursed on-call coverage is fair, and there are 10 specialists, then that leaves only about 10 days per month that the hospital would need to cover with a compensation arrangement, Sheff said.

Following are other recommendations made by speakers during the audioconferences for managing the on-call specialist shortage:

- Educate your physicians about the EMTALA law. In a study published in the *American Journal of Emergency Medicine* in 2003, researchers found that only 30% of the medical staff at a 900-bed, private tertiary hospital had ever heard of EMTALA.
- Make participation as a provider contingent upon taking on-call duties if your health system has a managed care plan, advised Jim Hubler, MD, JD, risk consultant for the Sullivan Group in Oakbrook Terrace, IL. One Illinois hospital succeeded in getting a major employer in the area to require on-call duties as a condition for providers to participate in its employee plans, he said. Hospitals can also tie operating room (OR) privileges to taking call.
- Maintain a list that has the names and phone/pager numbers of individual physicians—not group practice or answering service numbers—so the hospital ED can more easily contact specialists.
- Prohibit employees from furnishing financial information to on-call physicians over the phone; such an inquiry combined with refusal to come in can lead to an EMTALA violation.
- Pay specialists an activation fee. Instead of paying them for taking call, pay them for providing services if services are needed.
- Require specialists who are allowed to schedule elective surgeries while on call to arrange for appropriate backup if they are not available.
- Document the name and address of any physician on call who failed to appear within a reasonable time to furnish stabilizing treatment for a patient. Include that information on the patient transfer form if the hospital needs to transfer that patient.

Other strategies offered by Sagin for addressing the on-call specialist shortage include the following:

- Encourage older medical staff members to continue to practice.
- Consider including a surgical hospitalist or a laborist on your staff.
- Contract with a multispecialty group or an ED group to take over responsibility for specialist coverage.
- Maximize use of nonphysician providers to care for patients when appropriate.
- Place patients in observation units to obviate the need to call in a specialist.
- Develop transfer agreements with other hospitals.
- Develop regional call coverage arrangements for specialty coverage.
- Address physicians’ liability concerns by subsidizing malpractice premiums in return for ED coverage.
- Offer nonmonetary perks for on-call coverage, such as preferred OR slots or parking privileges.
- Invite residents and fellows from another teaching institution to follow patients at your facility.
- Allow departments to establish the on-call schedule rather than the medical executive committee.
- Allow physicians to subcontract their on-call obligation to another physician.
- Strengthen the ED group’s clinical skills to lessen the need to call on medical staff.
- Close specific lines of businesses.
The ins and outs of billing for shared visits

It’s not always the most efficient use of provider time

When working with nurse practitioners (NP) and physician assistants (PA), hospitalists must be clear about which clinical responsibilities each will have so there is no duplication of effort and no gaps in patient care.

For billing purposes, hospitalists and PAs or NPs also must be clear about which services will be billed by the individual providers and which will be billed as “shared visits.” In a shared visit, a physician and nonphysician practitioner (NPP) who are either from the same group practice or employed by the same organization each provide a portion of the face-to-face evaluation and management (E/M) service to the patient.

Each provider documents his or her own portion of the encounter with the patient. An NP could provide most of the service as long as the hospitalist/physician also sees the patient on the same day, says Jan Towers, PhD, NP-C, CRNP, FAANP, director of health policy for the American Academy of Nurse Practitioners.

In a shared visit, practitioners must meet the following criteria:

- Both the NPP and physician must see the patient face-to-face on the same day and perform part of the E/M visit.
- Both must independently document their face-to-face visit with the patient.
- The visit may be billed under the NP or physician (not both) using the combination of documented services to support the level of E/M for billing.

When a PA provides services, the visit is billed under the physician.

Reimbursement vs. time management

In an effort to bill for 100% rather than 85% of services, many hospital medical programs make a point of having hospitalists conduct face-to-face visits with the patients whom PAs and NPs are managing, says Michael Powe, director of policy for the American Academy of Physician Assistants. But he says hospitalists may want to rethink that approach.

It often is more efficient and productive for the physician and the NPP to bypass that visit by the physician when the patient’s condition doesn’t necessitate the hands-on involvement of the physician, Powe says.

Although PAs and NPs will bill at the lower reimbursement level (85%), the providers may be able to schedule their time more efficiently and effectively. Physicians may be able to see more acutely ill patients if they do not have to do a same-day visit with patients who have been seen and managed by the NPs and PAs, Powe says.

“THE BOTTOM LINE IS THAT THE REVENUE IS OFTEN HIGHER UTILIZING THAT APPROACH,” Powe says. “Practitioners are able to design their practice patterns not around reimbursement, but around efficient and optimal patient care.” Towers says she strongly agrees.
Shared visits

with this approach and acknowledges that providers can get more done if they are not trying to meet the shared-visit requirements.

If the physician doesn’t see a patient, it doesn’t mean that the physician is not actively involved in the care of that patient, Powe says. Chart review and discussion of treatment plans between the physician and the PA serve to keep the physician in the loop regarding patient care, he says.

Consultations cannot be billed as shared visits, says Powe. He notes that shared visits with NPPs are different than billing for care provided by residents under the teaching physician rules. Under those rules, the resident’s precepting physician must be present during the key portion of the service or participate in the key components of the service (i.e., history, exam, medical decision-making, etc.).

According to the most recent Society of Hospital Medicine survey of hospitalists and hospitalist leaders, the top six functions of NPs and PAs in a hospital medical program are as follows:

- Round on patients—83%
- Write prescriptions—82%
- Perform history and physicals—77%
- Communicate with primary care physicians—72%
- Act as initial responder—66%
- Participate in discharge planning—66%

The role of NPs

Billing and reimbursement issues aside, a more bothersome concern for NPs is staff resistance to verbal orders from NPPs and some hospitals’ requirements that NP orders be countersigned, Towers says. Medicare requires a physician’s countersignature on the first visit with the patient, she adds.

But in subsequent care of the patient, a hospital policy requiring a physician’s countersignature is often not an appropriate or necessary use of the clinician’s time, she says.

Towers adds that nurse practitioners would like greater recognition for the services they provide in shared visits. “Being the hidden provider does not sit well with us,” she says.