THE CENTERS FOR MEDICARE & MEDICAID SERVICES' QUALITY IMPROVEMENT ROADMAP

July 2005

EXECUTIVE SUMMARY

VISION: *The right care for every person every time.*

AIMS: *Make care safe, effective, efficient, patient-centered, timely, and equitable.*

The Centers for Medicare & Medicaid Services (CMS) believes that this vision and these aims are realistic and substantially achievable, and that recent developments create unprecedented opportunities and need for that achievement:

- A growing body of evidence shows there are major opportunities to improve care with major potential benefits for patients, providers, and payers.
- The growing complexity of medical knowledge and the growing number of participants, technologies, and specialties create both enormous rewards for better care and enormous challenges in continuing our current path.
- Leading providers are innovating to improve systems of care, and many stakeholders are showing a new willingness to come together in partnerships to achieve improvement. They are recognizing that the highest quality care is the only care anyone can now afford, and they are looking to CMS as essential partners.

CMS is focusing on these opportunities because its size and broad impact make it a public health agency. How the agency acts influences both the health care system and the care it delivers. CMS intends to meet the responsibilities that its influence imposes, and achieve the quality aims, through a set of system strategies linked to specific, clear steps to achieve transformational improvements in health care.

SYSTEM STRATEGIES:

The first part of the roadmap is to implement five major system strategies for improving care:

1. Work through partnerships, including within CMS and HHS, with other Federal and State agencies, and with nongovernmental partners including health professionals.

2. Publish quality measurements and information, including measures directed toward both the beneficiary audience and the professional/provider/purchaser audience.

3. Pay in a way that expresses our commitment to supporting providers and practitioners for doing the right thing – improving quality and avoiding unnecessary costs – rather than directing more resources to less effective care.

4. Assist practitioners and providers in taking advantage of CMS quality initiatives and make care more effective and less costly, in particular greater use of effective electronic health systems.

5. Become an active partner in driving the creation and use of information about the effectiveness of healthcare technologies, to bring effective innovations to patients more rapidly and to help doctors and patients use the treatments we pay for more effectively.

CMS expects that these strategies, implemented with partners throughout the health care system, will help promote changes in the culture of health care organizations that can lead to transformational improvements in health care quality. The second part of the quality roadmap links these system strategies to some particular areas of great opportunity for improving quality and avoiding unnecessary health care costs.

ACTIONS:

- As it implements the new roadmap, CMS will work with partners to: Expand CMS' public promotion of quality improvement and transformation in the healthcare system;

- Pursue transformational breakthroughs in surgical complication prevention; cardiac care; vascular access for dialysis patients; immunization in nursing homes, dialysis facilities, and home health; reductions in restraints and pressure ulcers in nursing homes; and possibly on other topics, in close partnership with multiple stakeholders;

- Strengthen partnerships within CMS and between CMS and other government agencies;

- Create, in close partnership with other stakeholders, performance measurement systems that support these payment systems and that move the healthcare system toward fulfilling the six aims, especially that of patient-centered care;

- Expand public reporting to reflect expanded quality measures;

- Design, for each major care setting, modifications to payment systems that encourage the right care, and implement them as the law allows;

- Assist providers and practitioners in improving their performance on these measures;

- Implement an Agency-wide health information strategy that supports the Department's transformational health IT strategy for the broad implementation of effective health information technology;

- Develop an Agency-wide strategy to promote use of covered preventive services;

- Implement strategies to make maximum use of existing and new data sources on the actual delivery of health care (such as data for the prescription drug benefit) to develop better evidence on the safety, effectiveness, and cost of healthcare technologies and practices;

- Implement, in close partnership with states, a strategy to improve quality of care for Medicaid beneficiaries; and

- Continue to establish, update, and enforce the agency's other traditional responsibilities in quality protection and improvement, reinforced by our new emphasis, collaboration, and evidence related to quality of care.

Implementing the quality roadmap will feature focused, collaborative "breakthrough" projects to demonstrate the feasibility of major health care improvement. For example, promoting appropriate immunizations in nursing homes might involve a partnership with stakeholders (by the CMS Long-term Care Task Force), addressing the payment for administering vaccine (Center for Medicare Management), requiring that vaccines be offered to every patient (Office of Clinical Standards and Quality) and enforcing that requirement (Center for Medicaid and State Operations), including immunization status in information that nursing homes report to CMS (Office of Clinical Standards and Quality), publishing each home's immunization rate (Center for Beneficiary Choices), and providing technical assistance and promoting staff immunization (Office of Clinical Standards and Quality). These actions require strong coordination to help ensure that the activities of many CMS components come together to change care, and strong collaboration with other stakeholders in the health care system that have a shared goal of transformational quality improvement.

To implement these initiatives, CMS has redesigned and strengthened its Quality Council, now chaired by the Administrator, and has created workgroups to achieve specific progress in such areas as health information technology, performance measurement and pay-for-performance, technology and innovation, prevention, Medicaid and SCHIP, long-term care, cancer care, and methods for breakthrough improvement. These workgroups, with membership drawn from across CMS, report to the Quality Council, which reviews, approves, tracks and supports their work in each component of the agency.

Accessed from: http://www.cms.hhs.gov/quality/quality%20roadmap.pdf on October 6, 2005. The complete document can be accessed at the above URL.

CMS Hospital Projects Overview
— *Identified Participant Groups* —

Health Services Advisory Group (HSAG) is pleased to invite Arizona hospitals to participate in national quality improvement projects, called *Identified Participant Groups (IPGs)*. As the CMS-contracted Quality Improvement Organization (QIO) for Arizona, HSAG will provide IPG-participating hospitals with evidence-based interventions, consultative services, technical assistance with performance measurement, professional society partnering, and educational opportunities designed to improve outcomes, decrease costs, and improve efficiency to achieve system-level changes. Each IPG has eligibility requirements and limited enrollment.

Appropriate Care Measure (ACM)

The ACM is composed of the 10 quality measures (5 AMI, 3 PN, and 2 HF) as defined in the Medicare Modernization Act (MMA) and associated with the hospitals' Annual Payment Update (APU). Unlike past quality efforts, in which each indicator was measured separately, the ACM is *patient-centered*. It answers the question: "Did the patient receive ALL the care he or she should have received, based upon his or her clinical condition?" Teams will focus on reducing the gap between care the patient *should have* received and care the patient *did* receive.

Surgical Care Improvement Project (SCIP)

SCIP is a national effort to reduce preventable complications related to surgical infections and thromboembolic events. These complications take a toll, not only on the patients, but also on the overall cost of health care through increased length of stay and hospital costs. The project quality measures have been developed in association with nationally recognized professional associations. Teams will participate in learning sessions and implement interventions designed to improve surgical processes and reduce surgical complications.

Systems Improvement and Organizational Culture Change (SIOC)

SIOC addresses issues related to use of advancing technology for health care and patient safety. Arizona is nationally recognized for its excellent telehealth network through the work of the Arizona Telehealth Program (ATP). Teams will use a CMS survey to assess their hospitals' current telehealth status, develop a business case for use or further advancement of telehealth, implement interventions to support the work, and conduct a second survey to determine improvement.

Rural Organizational Safety Culture Change (ROSC)

ROSC is designed to assist rural and critical access hospitals (CAHs) in assessing their organizations' safety climate through a survey developed by the Agency for Healthcare Research and Quality (AHRQ)—the *Hospital Survey on Patient Safety Culture*. Teams will assess their hospitals' current culture using the survey, identify opportunities for improvement, implement interventions, and conduct a second survey to determine improvement.

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Hospital Quality Alliance (HQA)
Hospital Quality Measures
2004-2007

	Release: 11/04 "Starter Set" [1]	Release: 4/1/05 7 Additional Measures [2]	Release: 9/1/05 3 Additional Measures [3]	Release: 2006 1 Additional Measure [4]	Release: 2007 (est.) 1 Additional Measure [5]
Acute Myocardial Infarction (AMI)					
• Aspirin at arrival	✓	✓	✓		
• Aspirin prescribed at discharge	✓	✓	✓		
• ACE inhibitor (ACE-I) for left ventricular systolic dysfunction (Measure will become "ACE-I or Angiotensin Receptor Blocker(ARBs) for left ventricular systolic dysfunction"; effective for 1Q2005 discharges)	✓	✓	✓		
• Beta blocker at arrival	✓	✓	✓		
• Beta blocker prescribed at discharge	✓	✓	✓		
• Thrombolytic agent received within 30 minutes of hospital arrival		★	✓		
• Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival (Measure was previously "PTCA received within 90 minutes of hospital arrival"; effective for 3Q2004 discharges)		★	✓		
• Adult smoking cessation advice/counseling		★	✓		
Heart Failure (HF)					
• Left ventricular function assessment	✓	✓	✓		
• ACE inhibitor (ACE-I) for left ventricular systolic dysfunction (Measure will become "ACE-I or Angiotensin Receptor Blocker(ARBs) for left ventricular systolic dysfunction"; effective for 1Q2005 discharges)	✓	✓	✓		
• Discharge instructions		★	✓		
• Adult smoking cessation advice/counseling		★	✓		
Pneumonia (PNE)					
• Initial antibiotic received within 4 hours of hospital arrival	✓	✓	✓		
• Oxygenation assessment	✓	✓	✓		
• Pneumococcal vaccination status	✓	✓	✓		
• Blood culture performed before first antibiotic received in hospital		★	✓		
• Adult smoking cessation advice/counseling		★	✓		
• Appropriate initial antibiotic selection			★		
• Influenza vaccination (Collected but not reported earlier due to vaccine shortage in 2004)				★	
Surgical Infection Prevention (SIP)					
• Prophylactic antibiotic received within 1 hour prior to surgical incision			★		
• Prophylactic antibiotics discontinued within 24 hours after surgery end time			★		
Hospital-CAHPS (HCAHPS)					
• Patient perspectives on hospital care					★
TOTALS	**10**	**17**	**20**	**21**	**22**

Note: All measures are endorsed by the NQF and common to CMS and the JCAHO Core Measure Sets. Additional measures may be added by the HQA for public reporting during 2006 and 2007.

Footnotes

1. Original 10 measure set used by both HQA and Section 501(b) of Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
2. Effective for discharges on or after 2Q2004, 7 new clinical measures (★) , for voluntary reporting by HQA-participating hospitals.
3. Effective for discharges on or after 3Q2004, 3 new clinical measures (★), for voluntary reporting by HQA-participating hospitals.
4. Effective for discharges on or after 3Q2005, 1 new clinical measure (★), for voluntary reporting by HQA-participating hospitals.
5. Data from HCAHPS, the patient perspectives on hospital care survey, expected to be available for public reporting in 2007

REV.8/22/05

REWARDING SUPERIOR QUALITY CARE: THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION

CENTERS FOR MEDICARE & MEDICAID SERVICES
FACT SHEET
August 2005

The Premier Hospital Quality Incentive Demonstration will recognize and provide financial rewards to hospitals that demonstrate high quality performance in a number of areas of acute care. The demonstration involves a CMS partnership with Premier, Inc., a nationwide organization of not-for-profit hospitals, and will reward participating top performing hospitals by increasing their payment for Medicare patients. Participating hospitals' performance under the demonstration will be posted at www.cms.hhs.gov for health care professionals.

Overview

CMS is pursuing a vision to improve the quality of health care by expanding the information available about quality of care and through direct incentives to reward the delivery of superior quality care. Through the Premier Hospital Quality Incentive Demonstration, CMS aims to see a significant improvement in the quality of inpatient care by awarding bonus payments to hospitals for high quality in several clinical areas, and by reporting extensive quality data on the CMS web site. Premier was selected for the demonstration because, through its database of hospitals in the Premier Perspective system, it has the ability to track and report quality data for 34 quality measures for each of its hospitals. This capability to immediately provide such a broad set of quality data makes the Premier database operationally unique and enables a rapid test of the concept of incentives for high performance in several areas of quality.

Quality of Care

Under the demonstration, top performing hospitals will receive bonuses based on their performance on evidence-based quality measures for inpatients with: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. The quality measures proposed for the demonstration have an extensive record of validation through research, and are based on work by the Quality Improvement Organizations (QIOs), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality, the National Quality Forum (NQF), the Premier system and other CMS collaborators.

Hospital Scores

Hospitals will be scored on the quality measures related to each condition measured in the demonstration. Composite quality scores will be calculated annually for each demonstration hospital by "rolling-up" individual measures into an overall quality score for each clinical condition. CMS will categorize the distribution of hospital quality scores into deciles to identify top performers for each condition.

Financial Awards

CMS will identify hospitals in the demonstration with the highest clinical quality performance for each of the five clinical areas. Hospitals in the top 20% of quality for those clinical areas will be given a financial payment as a reward for the quality of their care. Hospitals in the top decile of hospitals for a given diagnosis will be provided a 2% bonus of their Medicare payments for the measured condition, while hospitals in the second decile will be paid a 1% bonus. The cost of the bonuses to Medicare is projected to be about $7 million a year, or $21 million over three years.

Improvement Over Baseline

In year three, hospitals that do not achieve performance improvements above demonstration baseline will have adjusted payments. The demonstration baseline will be clinical thresholds set at the year one cut-off scores for the lower 9th and 10th decile hospitals. Hospitals will receive 1% lower DRG payment for clinical conditions that score below the 9th decile baseline level and 2% less if they score below the 10th decile baseline level.

Public Reporting

Hospitals participating in Premier Hospital Quality Incentive Demonstration reported previously collected quality data currently available in the Premier Perspective database to provide a historical reference on these quality indicators. The data was published at www.cms.hhs.gov in early 2004. The first year results will be reported in 2005 recognizing those hospitals with the highest quality and noting those hospitals that received bonus awards.

Hospital Participation

Participation in the demonstration was voluntary and was open to hospitals in the Premier Perspective system as of March 31, 2003. More than 270 hospitals are participating in the demonstration. CMS will use the Premier demonstration as a pilot test of this concept, and may develop a request for additional proposals for this concept once we obtain results from the evaluation of the Premier demonstration.

The Premier Hospital Quality Incentive Demonstration: Clinical Conditions and Measures for Reporting

The CMS/Premier quality measures are based on clinical evidence and industry recognized metrics. For example, they include:

- All ten indicators from the starter set of "The National Voluntary Hospital Reporting Initiative: A Public Resource on Hospital Performance." (AHA Initiative)
- Twenty-seven indicators are National Quality Forum (NQF) indicators.
- Twenty-four indicators are CMS 7th Scope of Work indicators.
- Fifteen indicators are JCAHO Core Measures indicators.
- Three indicators are proposed by The Leapfrog Group.
- Four indicators are the Agency for Healthcare Research and Quality (AHRQ) patient safety indicators.

Clinical Conditions	Measures
Acute Myocardial Infarction (AMI)	1. Aspirin at arrival [1,2,3,4, P] 2. Aspirin prescribed at discharge [1,2,3,4. P] 3. ACEI for LVSD [1,2,3,4,P] 4. Smoking cessation advice/counseling [1,2,3,P] 5. Beta blocker prescribed at discharge [1,2,3,4,P] 6. Beta blocker at arrival [1,2,3,4,P] 7. Thrombolytic received within 30 minutes of hospital arrival [1,2,10,P] 8. PCI received within 120 minutes of hospital arrival [1,5,10,P] 9. Inpatient mortality rate [1,3,6,O]
Coronary Artery Bypass Graft (CABG)	10. Aspirin prescribed at discharge [5,P] 11. CABG using internal mammary artery [1,5,P] 12. Prophylactic antibiotic received within 1 hour prior to surgical incision [1,2,10.P] 13. Prophylactic antibiotic selection for surgical patients [1,2, 10,P] 14. Prophylactic antibiotics discontinued within 24 hours after surgery end time [1,2,10,P] 15. Inpatient mortality rate [7,O] 16. Post operative hemorrhage or hematoma [8,O] 17. Post operative physiologic and metabolic derangement [8,O]

Clinical Conditions and Measures for Reporting and Incentives (cont'd)

Clinical Conditions	Measures
Heart Failure (HF)	18. Left ventricular function (LVF) assessment [1,2,3,4,P] 19. Detailed discharge instructions [1,2,3,P] 20. ACEI for LVSD [1,2,3,4,P] 21. Smoking cessation advice/counseling [1,2,3,P]
Community Acquired Pneumonia (CAP)	22. Percentage of patients who received an oxygenation assessment within 24 hours prior to or after hospital arrival [1,2,3,4,P] 23. Initial antibiotic consistent with current recommendations [1,2,10,P] 24. Blood culture collected prior to first antibiotic administration [1,2,3,P] 25. Influenza screening/vaccination [1,2,10,P] 26. Pneumococcal screening/vaccination [1,2,3,4,P] 27. Antibiotic timing, percentage of pneumonia patients who received first dose of antibiotics within four hours after hospital arrival [1,2,4,10,P] 28. Smoking cessation advice/counseling [1,2,3,P]
Hip and Knee Replacement[9]	29. Prophylactic antibiotic received within 1 hour prior to surgical incision[1,2,9,10,P] 30. Prophylactic antibiotic selection for surgical patients [1,2,9,10,P] 31. Prophylactic antibiotics discontinued within 24 hours after surgery end time [1,2,9,10,P] 32. Post operative hemorrhage or hematoma [8,9,O] 33. Post operative physiologic and metabolic derangement [8,9,O] 34. Readmissions 30 days post discharge [9,O]

[1] National Quality Forum measure
[2] CMS 7th Scope of Work measure
[3] JCAHO Core Measure
[4] The National Voluntary Hospital Reporting Initiative (AHA Initiative)
[5] The Leapfrog Group proposed measure
[6] Risk adjusted using JCAHO methodology
[7] Risk adjusted using 3M™ All Patient Refined DRG methodology
[8] AHRQ Patient Safety Indicators and risk adjusted using AHRQ methodology.
[9] Medicare beneficiaries only
[10] CMS and/or JCAHO to align with this measure in 2004
[P] Process measure
[O] Outcomes measure

Hospitals & Health Networks welcomes your comment on this article. E-mail your comments to hhn@healthforum.com, fax them to *H&HN* Editor at (312) 422-4500, or mail them to Editor, *Hospitals & Health Networks*, Health Forum, One North Franklin, Chicago, IL 60606.

The Rise of Hospitalists, Part 1

By Richard Vernick, M.D., and Mitchell Wilson, M.D.

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The field of hospital medicine, the general medical care of hospitalized patients, continues to grow. The number of hospitalists working nationwide expanded from a few hundred in the mid-1990s to more than 8,000 in 2003. By the end of this decade, their number is expected to more than triple--to 25,000.

Hospitalists are not only growing in number; they are permeating hospital care. In Massachusetts, for example, only four out of 75 acute care hospitals had hospitalist programs in 1996. Today, 210 hospitalists coordinate care for 42 percent of 1.8 million inpatient days annually.

But perhaps the most significant issue concerning hospital medicine is not its rapid growth but the impact it's having on the way health care is delivered. The Center for Studying Health System Change--which recently published the results of a hospitalist market trend study, *Health Care Market Trends and the Evolution of Hospitalist Use and Roles,* in the February 2005 issue of the *Journal of General Internal Medicine*--described it this way: "Hospitalists most commonly care for patients whose physicians prefer not to provide inpatient care or who lack admitting privileges. However, hospitalists' clinical roles are expanding, for example, as they increasingly substitute for intensivists in ICUs, team with subspecialists to care for complicated patients, function as primary attending physicians in skilled nursing facilities and care for nursing home patients hospitalized at night."

As hospitals struggle with increasing financial pressures, a growing shortage of primary care physicians willing to cover the hospital, and problems with patient flow and safety issues, many are turning to hospitalist programs for solutions--often with great success.

Questions to Ask Yourself

If you're a CEO interested in starting a hospitalist program, consider the five issues below. They will help you determine what sort of program will best suit your organization, how it should be implemented and how your organization will pay for it.

What do you want out of a hospitalist program? Generally speaking, two issues drive the development of most hospitalist programs: service and care management.

Some of the most common needs regarding service include:

- Managing admissions on behalf of the physicians, which improves their lifestyle and allows them to focus on outpatient volume.

- Providing prompt, attending physician services to patients without regular physicians and often without insurance or financial resources.
- Providing on-site, 24/7 physician coverage to hospitalized patients.

Some of the most common needs regarding care management include:

- Efficient use of resources, resulting in a decreased cost per case.
- Improved patient satisfaction due to increased physician presence.
- Improved quality of care due to the physician's increased familiarity with hospital procedures and processes.
- Improved compliance with order sets and standards of care.
- Improved throughput, better capacity management and decreased length of stay.
- Improved ED performance due to facilitated admission procedures.

What type of hospitalist program do you need? There are at least four basic models or types of hospitalist programs. Each has its advantages and drawbacks, depending on your market and immediate needs. It is important to understand the pros and cons of each model before you begin--just as it is important to realize that hospitals often find themselves "mixing and matching" one or more types--especially when they're just getting started. The following information comes from a 2004 productivity and compensation survey by the Society of Hospital Medicine.

Hospitalist program by model/type	Percent of hospitalists employed by type
• Hospital/hospital corporation	34%
• Single specialty/multispecialty group	16%
• Local hospitalist-only group	16%
• Multistate hospitalist-only group/hospitalist management company	9%
• Other (includes medical schools/academic programs, which may operate a mixed model)	25%

Research the pros and cons of each type of hospitalist program to determine which model best fits your needs. Talk with someone who knows hospital medicine from the inside out. You may choose a consultant who can introduce you to the topic, evaluate the level of your needs and make recommendations. Or you might contact hospitals with established hospitalist programs to gain insights into the development and growth process of the program, as well as the problems encountered, the costs and other factors.

How will you gain acceptance from your medical staff? Acceptance by the physician community is critical--as is selling the concept to your medical staff. Depending on the market and type of hospitalist model you choose, the medical staff may perceive a hospitalist program as a competitive venture. Physicians are concerned about patient retention and satisfaction, as well as discontinuity of care.

Typically, when they're developing a new clinical service, hospital administrators will form a committee of doctors from the medical staff and start inviting vendors to make presentations. The act of bringing in vendors--such as a hospitalist management company or local hospitalist-only group--can raise all kinds of red flags among various

interest groups if it's done too soon or not handled properly. You could wind up solidifying opposition to the program before it ever gets off the ground.

It's a good idea to find a physician who can champion your cause--someone who can be an advocate for implementing a hospital medicine service. This physician should be someone who has the communication ability, business savvy and clinical care legitimacy within the community, so he or she can also represent the conscience of the physicians.

How will you pay for this program? Costs will vary, depending on the type of hospitalist model you choose, the payer mix and service requirements. On average, hospitalists will cost approximately $75,000 or more per FTE than the pro fee offset. A full-blown program with 24/7 coverage requires a staff of six hospitalists to stay within the benchmark numbers of shifts or hours per year.

If you're in a market where you want the hospitalist to provide unassigned and unfunded coverage, then the hospital must pay for the program based on other metrics or soft targets such as optimizing resource utilization, length of stay and so forth.

Hospitalist programs prove their worth by decreasing unnecessary consumption of hospital resources and increasing efficient handling of patients. Any savings that accrue from more efficient care, shorter length of stay, reduced use of resources and quicker disposition go directly to the bottom line.

Make or buy? After defining your short- and long-term goals for the program, and determining the costs involved, you must decide whether you want to build your own program or buy one. Again, that decision depends on your needs and goals. If, for example, your hospital is drowning because you're at 100 percent capacity, your ED's on bypass all the time or you have a lot of unsponsored care, you may need to jump-start your program by contracting with a multistate hospitalist-only management group. On the other hand, you may decide to start off slowly with a call-based system of hospitalists that can evolve into a 24/7 program--either comprised of hospital-employed doctors or contracted with a local hospitalist-only group.

A New Way to Deliver Health Care

The numbers suggest that hospital medicine is here to stay. Whether you decide to have a hospitalist program or not, remember that as the field of hospital medicine grows, it will impact the way you and the doctors in your community do business. Hospitalists have been called "a new breed of physician"--fueling a debate over whether hospital medicine will eventually become a new specialty. No matter how that is resolved, hospitalists are clearly creating a new breed of health care delivery.

The Rise of Hospitalists, Part 2

Most CEOs we've spoken with are shocked by how rapidly--and in how many different ways--hospital medicine is changing the medical landscape.

Rapid growth, for example, catches many hospitals unprepared. Within six to 12 weeks of opening the program, the demand outstrips the program's ability to provide hospitalist services. The hospitals simply don't have the infrastructure or personnel to handle the load. Over the long term, this often leads to high turnover and staff burnout.

Or many hospitals suddenly find themselves juggling an impromptu "mix-and-match" situation in which competing hospitalist groups--using different program models--offer services that may have little to do with the hospital's needs or goals. Without the time or necessary tools to assess or control the process, many hospital administrators feel like passengers on a runaway train.

A hospital may also find itself with three or four hospitalist programs competing to become the designated inpatient provider for an insurance plan. Alternatively, the hospital may suddenly have to deal with credentialling issues for practices that no longer do much inpatient work.

Hospitalist Program Models

Understanding the pros and cons of each program model--and how it does or does not match your needs--may help you prepare for rapidly changing circumstances.

Hospital-owned or hospital-employed model. Under this model, the hospital builds its own program.

Pros:

- You can design, build and adjust the program (hire and fire, set policies and priorities) to fit your particular needs.
- You have a greater ability to incorporate quality and financial gain-sharing with fewer regulatory burdens.
- Physician incentives can be set to match the hospital's goals, plus improve your infrastructure and processes of care.
- This model generally does not give a competitive edge to one medical group over another.
- A doctor on call might be more inclined to transfer or admit a patient to a hospital with 24/7 coverage because he or she won't have to go in.

Cons:

- Inpatient care once provided by PCPs must now be paid for by the hospital.
- Civil monetary penalties, liability and compliance are now the hospital's responsibility.
- If the contract does not include a well-structured incentive package, you run the risk of getting stuck with doctors who are there just to collect a paycheck.

Single-specialty or multispecialty group model. Under this model, a private practice group or HMO may provide inpatient care only for its own patients--unless it has a contract with the hospital for additional coverage.

Pros:

- The hospital has limited financial responsibility.
- The workforce is "built in" and may not require recruitment or startup time.
- Because hospitalists can handle initial evaluation/triage and consult as needed, this may solve ED coverage issues with subspecialists and may even assist medical staff recruiting.

Cons:

- This model is not necessarily designed to increase volume or access for the hospital.
- Unless there is a contract to align goals, the hospital cannot drive performance or quality.
- The group may not send patients back to the hospital for follow-up care because they want to encourage use of their own clinic-based ancillary services.
- Medical staff relationships may deteriorate: Some groups may form competing hospitalist services while the hospital may be perceived as showing favoritismto any group that contracts for additional work.
- Multispecialty hospitalist groups continue to decline in numbers--either because the group is reluctant to subsidize the additional expense of the program or because its hospitalists become so successful that they form their own hospitalists-only group.

Local hospitalist-only group model. Under this model, a private practice group is locally owned and operated. This model shares many of the same advantages and disadvantages of the hospital-owned model--especially if the hospital works out a contract that aligns performance expectations with its goals.

Pros:

- Typically, these are entrepreneurial physicians who set up their own group. If set up as a call-based arrangement, this model can be very economical, with limited financial responsibility for the hospital.
- These physicians know the local environment. Presumably, they understand the wants and needs of the hospital and may already have relationships with some of your physicians.

Cons:

- In densely populated markets, it is common for these groups to work at two to three hospitals. Conversely, in smaller markets, it may be difficult to find an existing group.
- If the hospitalist group is responsible for its own bottom line, its incentives may be driving volume and new patient encounters without an equal emphasis on quality or resource management.

Large multistate or regional hospitalists-only group management company. Under this model, for-profit companies either employ the hospitalists or manage the program.

Pros:

- The companies have a readymade infrastructure: protocols and quality measures, communications methodologies, and billing and collection procedures. They know the coding and can provide the necessary staff education to jump-start the program.
- They can assist with recruiting--and often have a wider recruitment capability than the hospital. Usually, they can get physicians in and started quickly.

Cons:

- Though the companies' initial startup costs may be low, their contracts are usually structured so they own a piece of the program.
- Their readymade programs may not fit your needs.
- They lack a sense of local ownership. Most of these physicians are not from the area, although the savvy companies will identify a local resource within the community and hire that person as the program leader.
- These companies are often fraught with turnover problems. Many of the doctors are hired right out of training.
- Typically, these companies take their fees in a variety of ways and may, in fact, be worth it in the first two years. Depending on your agreement, however, you may have a limited ability to use the knowledge you've paid for--or an option to transition into a locally owned and operated program.

Exerting Control over Quality

The impact of hospitalists on your organization depends on understanding the demographics and dynamics of your market, whether you've identified realistic short- and long-term goals for your hospitalist program, and how the strengths and weaknesses of each type of hospitalist program match those goals.

Remember: The larger the volume of inpatients seen per hospitalist, the greater the reliance on consultants and the more superficial the care. The smaller the volume of inpatients, the more closely resources are managed, and the lower the need for consults.

No matter which model or mixture of hospitalist program models you have in your organization, the most critical factor is ensuring that the hospital exerts contractual control over performance and quality.

HSAG Acute Care Team

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Attention: HSAG Acute Care Team—Suzanne Powell

Subject: Question from *Hospital Medicine* Conference