HOSPITALIST & INPATIENT MANAGEMENT REPORT

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Giving hospitalists a meaningful incentive

Good ideas for creating a great bonus system

Martin Buser, MPH, FACHE, sees a lot of hospitalist practices in his work as a partner with Hospital Practice Management, and it never ceases to amaze him that most of his clients have no incentive or bonus system in place for their hospitalists. "The bulk of them have fee-for-service programs with a flat subsidy from the hospital," he says.

The problem with such programs is that they really only work for newly minted physicians, Buser says. New doctors often have "a deer in the headlights look about them. They are just happy to have a job and get a paycheck." But after a couple of years, they start to get dissatisfied with the status quo, and if your group doesn't change as the physicians mature into their jobs, they are likely to start looking elsewhere.

It is perhaps one of the unforeseen consequences of static pay programs, but a no-brainer if you think about it. **Winthrop Whitcomb**, MD, director of the 12-hospitalist program at Mercy Medical Center in Springfield, MA, says if you continually ask physicians to do more and perform better, but you give them no incentive to do so, they aren't likely to stay happy in their jobs for very long.

But employee retention is just one of many opportunities lost in the wake of straight pay programs.

"I stonewalled for eight years before going to an incentive program," Whitcomb says. "The problem with straight salary is there is no incentive for hospitalists to capture their work with billable charges. They are not motivated to do additional tasks that are good for both patients and hospitals, like preoperative clinics or consults on the rehab unit. And you have added to it that they burn out much more quickly when faced with stretches without any incremental financial reward."

Incentive plan options

How to create incentives is another story. There are plenty of options available, and Buser says that what you choose is dependent on the specifics of your group. Three of the most common are:

1. Case rate: One of the incentive programs tied directly to productivity, this program pays

INSIDE . . .

the hospitalist a fee for each portion of the interaction from emergency department through discharge. For instance:

- ER evaluation resulting in discharge from the ER to the attending physician or appropriate SNF: $350.
- Admission H&P: $255.
- Day 2 E&M: $70.
- Day 3 E&M: $ 40.
- Day 4 and beyond E&M: 95% of current Medicare RBRVS fee schedule
- Invasive procedures: 95% of current Medicare RBRVS fee schedule

Buser says this isn't very common any more. Where it is used, usually base pay is lower than if another program was used.

2. Quality incentive program: Incentives paid are tied directly to improved performance in specific areas, often related to high-volume DRGs. Buser recommends choosing four areas each year on which to focus. One might relate to use of and adherence to clinical guidelines.

For example, if congestive heart failure were chosen as an area on which hospitalists wanted to focus, the physicians would be required to follow a CHF clinical pathway and prescribe ACE inhibitors upon discharge. Digressing from this norm would require documentation in the medical record 95% of the time.

Another item might relate to utilization. The hospital and hospitalists would agree on a methodology for tracking avoidable days, and physicians would be rewarded if they achieve some level of performance -- such as over 95% of the target. The third portion might relate to patient satisfaction. Hospitalists would have to achieve overall average scores of at least 90% on patient satisfaction measures.

Once the specific items on which to focus and their parameters are set by the hospital and hospitalists, money is put in the pot for division based on how many of these goals are met. Buser says it might be $100,000, with an equal portion available for meeting each of the goals. If the physicians met three of four goals, then $75,000 would be available to split as a bonus. Buser says each hospitalist should share equally in the available money and the hospital should consider paying it out quarterly.

3. Pay for productivity: Based on relative value units (RVUs), this relates bonuses to the total number of RVUs generated by each hospitalist. The RVUs each have a multiplier based on the dollar weight of each RVU. Night shifts are given an extra multiplier to compensate for being less productive, yet necessary.

There is sometimes a fear that using productivity as a method for incentivizing physicians could result in physicians either keeping patients in longer than they require, or admitting more borderline cases in order to gain some financial reward. However, Whitcomb discounts this. "The hospitalist ethic is to optimize patient length of stay. Part of our very identity is to send patients home as soon as they are ready. This may be a theoretical concern, but I haven't seen it borne out."

Further, he notes that most hospitalists are overly busy. They do not want an additional patient on their plate if that patient doesn't need to be there.

Don't fear productivity as an incentive

Having some method of rewarding hard work is vital, says **Ken Simone**, DO, administrative director of Northeast Inpatient Medical Service in Brewer, ME. "From an ethical perspective, maybe taking productivity out the bonus completely is simplest, but it is really something you want to measure. You may not want to pay per admission. You do not want to do it based on how much someone charges. You do not want it based on length of stay because that might lead to early releases. And you do not want it based on average daily census."

But the fear related to this kind of bonus structure is probably bigger than the reality suggests it should be. "If you look at trends, you are going to see outliers," Simone says. For instance, his group was looking at MRI and X-ray utilization. "We do not incentivize based on it, but we were looking at it. One physician was

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way up -- more than twice the other docs."

The reason was actually simple: she was the nighttime hospitalist doing admission. She had fewer patients, but they were usually admitted from the emergency department, they were very sick, and she often had to rule out stroke or heart attack. She was ordering the tests at the time of admission, rather than the physicians who were having more contact with the patient over the course of his or her stay.

In another instance, Simone recalls one physician just out of residency who was rather gung ho about addressing every ache and pain his patients had. If a pneumonia patient mentioned a sore ankle, this physician would work it up, Simone says. "It wasn't bad medicine, but maybe a little excessive. We monitored it for a while."

Along with being able to see outliers, Simone says RVUs have the advantage of taking the dollar out of the equation. "It is a different currency," he says.

Some incentive program examples

In Simone's eight-physician, three-mid-level group, the average RVU output is 20 per day, 100 per week for a full time physician. Those working 5 p.m. to 7 a.m. have 15 per day, 60 per week. A 48-hour weekend is 35 per day, 70 per week.

The program has common team goals that have to be met before the bonus program kicks in. If an individual fails to meet those goals, no physician gets a bonus. However, Simone says the baseline is easily attainable and has been met each time. Among those minimum goals:

- **Timeliness of billing.** In the early days, the physicians, who are salaried, were not great at submitting charges. Often it took them 10 days. Now, charges have to be submitted within 24 hours 98% of the time.
- **Meeting attendance.** Physicians must attend committee, practice, and medical staff meetings 80% of the time.
- **Coding and documentation.** Simone and the quality staff will pull 10 charges per provider per month and look for 80% accuracy in coding.

These minimum goals are looked at quarterly. Once they are met, individual goals kick in. They are divided up as follows:

- 40% is based on RVU and productivity;
- 5% based on clinical indicators, such as getting aspirin or beta-blockers for all MI patients;
- 10% is based on readmission rates; they are expected to be less than 4% for 30-day bounce-backs;
- 10% is based on timeliness of medical record completion; notes should be dictated within an hour of admission and signed within 24 hours; discharge summaries have to be done before the patient leaves the hospital;
- 10% is based on referring physician satisfaction survey, with 80% of the respondents reporting that they are satisfied or better; among the items on the survey are being informed of the admission, being updated daily, being involved in the treatment plan, agreeing with the treatment plan, and having an appropriate and complete discharge plan;
- 10% is patient satisfaction, with 80% of the responses being very good or better; among the items asked of patients are whether the patient was visited daily, how well they communicated with the patient and his or her family, rating the overall care, and how they felt they were treated;
- 5% is policy and procedure compliance;
- 10% is teamwork; this isn't really well defined, but is left up to the clinical director; and
- 5% of the base salary is available for bonus, which is administered quarterly.

Whitcomb's program is productivity aligned, based on charges multiplied by the prior year's collection ratio. A target is created

Must-have characteristics for hospitalist bonus and incentive programs

- Easy to understand
- Simple to administer
- Economically significant
- Affordable
- Data is accurate and reliable
- Able to adjudicate in a timely manner
- Feedback on performance is provided a regular basis
- Aligns practice results with the hospital's needs by reinforcing quality and cost effective behavior
- Provides similar incentives to physicians in private practice
- Quality patient care is enhanced
- Keeps the hospitalists' incomes in a market-competitive position
- Creates long-term win (hospitalist)-win (hospital)-win (patient) relationships

Source: Hospitalist Management Resources, LLC, Del Mar, CA

using the prior year's values. Once the target is met, 70% goes to the physician, 30% to the hospital. For example: Doctor A generates $90,000 in charges for the first quarter. Cash estimate - $90,000 x .50 (the prior year's collection ratio) = $45,000

At end of the first quarter, Doctor A gets $45,000 - 37,500 (25% annual target) = 7,500 x .70 (portion going to MD) = $5,250. Some portion is withheld to even out fluctuations in productivity throughout the year.

At year-end, Doctor A has generated an estimated $190,000 in cash. His total payout for the year is (190,000 -- 150,000) x .70 = $28,000. His year-end bonus check will be $28,000 minus whatever he has received year-to-date in bonus payments.

Performance counts

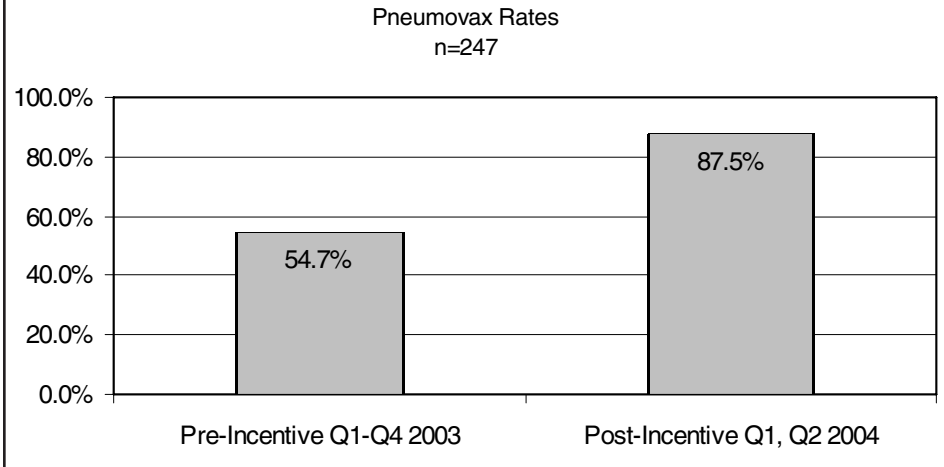
Another portion of the hospitalists' pay this year will be based on quality indicator performance, says Whitcomb. More than 5% of their base pay will be up for grabs for each physician based on meeting performance indicators. This bonus will be paid out twice a year and will be based on meeting the following goals:

- 45% screening for pneumovax and administration in pneumonia cases;
- 85% ACE inhibitor administration for CHF patients; and
- 85% left ventricular assessment in CHF patients.

Charts for pneumonia and CHF patients will be reviewed by a quality improvement nurse. Misses will be reported back to the hospitalists, who are to be kept apprised of their progress on these indicators regularly.

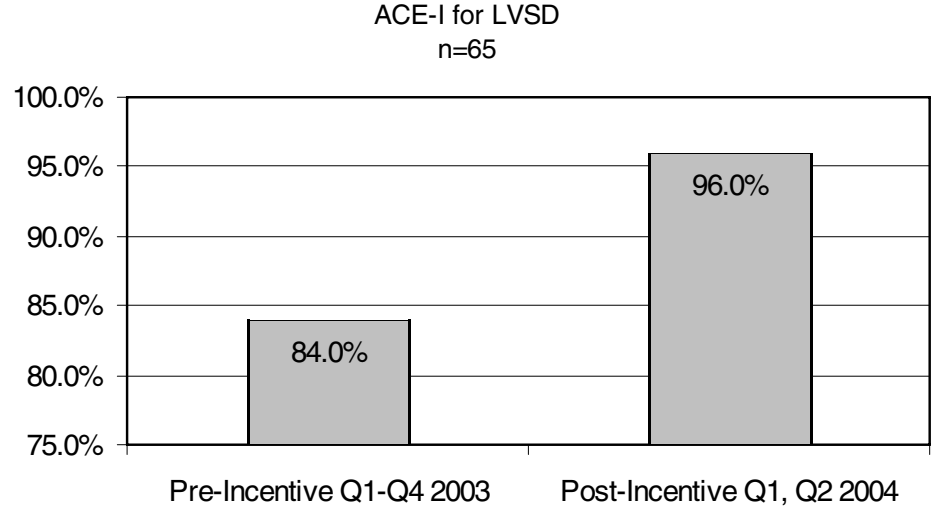
So far, the impact has been significant (see **Figures 1, 2**,

Figure 1: Effect of Financial Incentives on Quality
Mercy Inpatient Medicine Service
Introduced January 1, 2004



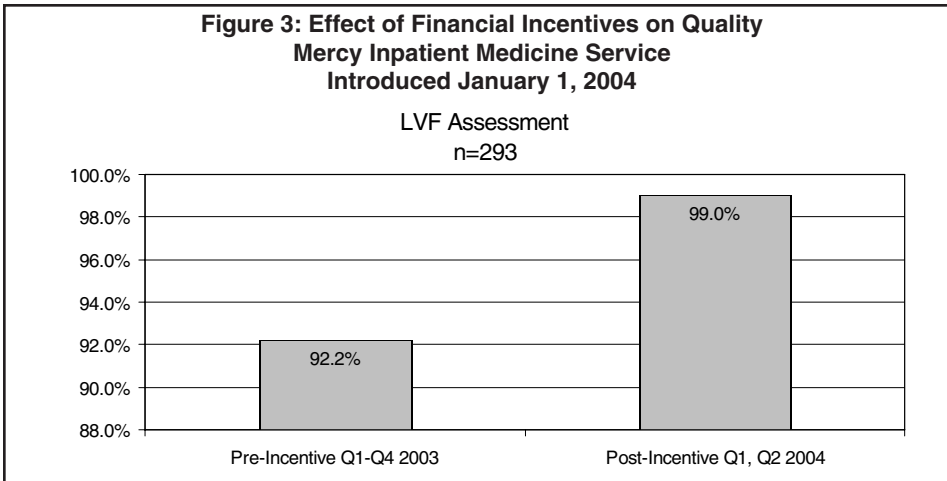
Source: Mercy Medical Center Springfield, MA.

Figure 2: Effect of Financial Incentives on Quality
Mercy Inpatient Medicine Service
Introduced January 1, 2004



Source: Mercy Medical Center Springfield, MA.

Figure 3: Effect of Financial Incentives on Quality
Mercy Inpatient Medicine Service
Introduced January 1, 2004



Source: Mercy Medical Center Springfield, MA.

and **3**.), with these indicators rising significantly beyond the goals in every case.

Whitcomb says the productivity portion pays dividends, too -- and these benefits are almost immediate. "You see better billing charge capture right away," says Whitcomb. "Some proportion of revenue will increase as they begin to bill more appropriately and aggressively." He adds that at least 5% of hospitalist pay should be at risk based on productivity.

Simone tells the story of one physician who hadn't been great about billing until they implemented their productivity incentive program. "He went from having 10-15% of his billing going out after 24 hours to the 2% goal in a single quarter." And Buser recalls one client who went from a straight pay program to a productivity based one. The practice saw a 15% increase in charges because the physicians got really good about billing on time and billing appropriately.

Simone says that incentivizing positive administrative behaviors is vital for the success of a hospitalist practice. "When I started this, there were things that bothered me, like billing and medical records. If I wanted to change the behavior, then I knew I had to create an incentive for that to happen."

Nurse, get me a flak jacket

Getting physicians to buy into the idea of a performance and/or productivity based bonus structure isn't always easy. Simone says the day he proposed it, it was very tense in the meeting. "I really wondered if I needed a flak jacket," he recalls. "But I explained that I wasn't trying to take anything away from them. I gave them a presentation, I fielded their questions."

Buser says the easy way around the fear is to run a parallel system. Pay the physicians as they have been for a quarter, but keep track of what they would make under the new system at the same time. "We have never gotten through the three months when we have done this," he says. "After a month, they wonder what we are waiting for."

Once you have a program in place, do not think you are done. Things change over time. Simone, who also works as a consultant to hospitalist groups, was working with a new practice in Delaware. Because the financial health of the practice will be paramount in the beginning, they decided to make appropriate coding one of the factors they look at. They also are emphasizing patient and physician satisfaction surveys. In the future, when they've got their bearings, those items or the weight they have in the bonus structure may change.

Buser says asking the hospital what issues they want to address will give you a constant stream of items on which to focus. For instance, if they have a new IS system that people will not use, you can put part of the bonus in a pot based on the hospitalists' use of the system and their willingness to act as champions for it by teaching courses and working with the medical staff. "You have the chance here to create a good dialogue with the hospital and align your incentives. No one ever asks them what they want to work on. They'll love you and when it comes time for renegotiating your contract, it looks great for you."

Buser says RVU-based incentive programs may last longer than others and need less tweaking. However, every year, the value you place on the RVU should be evaluated. Right now, one group Buser works with has an RVU value of $15. Next year, it may go up to $17. Other programs should also get an annual review. "This forces a sense of discipline," he concludes. "You do not just drift along for 10 years, but remain competitive and relevant to the market."

Editor's Note: Contact Winthrop Whitcomb at (413) 748-9000; Ken Simone at (207) 989-5698; and Martin Buser at (858) 481-7108. ☑

Getting to know you

How a good orientation program can improve retention

If new physician orientations are a part of expanding your practice that you hate with a passion, listen up: if you have a good orientation program, you might be able to increase your retention. Increase the length of time you can hold your best physicians and you may find you do fewer orientations. There are other reasons to have a good orientation program, but doesn't that one make you sit up and take notice?

"You must have an orientation program, and it must be formal -- more than just a half hour before a physician's first day where you show him where the doctor's lounge is," says **Mary Jo Gorman**, MD, MBA, chief medical officer of North Hollywood-based IPC -- The Hospitalist Company. "It is hard and it costs money. If you are already short-staffed, the temptation is to find a justification for not

doing this. But you must, not just because orientations provide information that every one of your doctors needs to know, but because it shows you care for them and value them. This is absolutely critical to the retention of your workforce, to the success of your physicians, to the success of your organization, and to the well being and satisfaction of your patients."

IPC hires about 80 new physicians every year, something that most hospitalist groups can't begin to match. That means that the company has a lot of experience in creating and refining physician orientation programs.

Initially, Gorman says they didn't have as beefy a program as they have now. "But it became apparent early on that the people we were hiring didn't know what it was to be a hospitalist. They knew the right antibiotic to give to someone with pneumonia. But our jobs as hospitalists are much more than that."

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>
> Mary Jo Gorman, MD, MBA
> IPC

Doctoring the system

The program emphasizes what is different about being a hospitalist than being a physician in an office. "Our goal is to be responsible for changing the system in which you work for the betterment of your patients," she says. "With a pneumonia patient, picking the right antibiotic is important. But you also have to be able to determine if they were given in a timely manner, whether the patient had to wait too long in the emergency department, whether the patient gets out of bed while in the hospital, and what the discharge needs for the patient are." If you find that one of those things isn't going well, you have to know how to fix it. It is not just doctoring the patient, but the system.

Residents may have experience in a hospital -- and Gorman says they are often fairly cocky about not needing orientation because of it -- but they aren't hospitalists. They aren't usually involved with case management or interactions with hospital administration and health plans. "I remember one resident raised his hand at a talk I gave and asked me what I had to teach him *really*," Gorman recalls. "Plenty. There's plenty to teach."

About half of the physicians she hires have no previous experience -- they are new doctors. The other half aren't much better at the hospitalist aspect of hospital care, since most of their experience in a hospital involves quick rounds made at 6 a.m. "Their interaction with the health care system is different than what a hospitalist has," she says.

Both groups go through the same orientation process at IPC. The first week, they are trained on the IPC technology. The physician also has two 60 to 90 minute modules with a senior IPC physician in their city. "These are on topics like what is a hospitalist, how it is different from an internist, and what the hospitalist role is," she says. There are modules on health care economics like DRGs and what an HMO is. "You'd be surprised how many people actually do not have that information." Physicians with experience may find the modules more conversational and less didactic. The physician providing the information can tailor it to the new physician's needs.

The new hires are guided through what constitutes medical necessity and what cues to look for to make a discharge. "We had a couple of residents who trained at VA facilities and discharge never crossed their minds."

A time to imprint

They also spend a half-day with a senior mentor physician in their area, but not from the same practice in which they will work. That half-day is spent on what the physician does, how to do rounds, and observation of the mentor working. "It is a time for them to imprint," Gorman says.

The physicians are then assigned to a practice partner. These are physicians who have special training. Only a small portion of the IPC physicians gets this designation, she says. "From them, they learn the nitty-gritty of the facility in which they will work -- where stuff is, who are good resource people."

On the fourth day, the new hospitalist will pick up a few admissions, the fifth day a few more. They are then off for the weekend. "The first full week is pretty controlled, with no more than 5 to 10 patients," Gorman explains. If the person is already on staff at the hospital,

it may be speeded up a bit.

Additional training modules are done with five or six other new physicians at a time, conferencing via telephone with a senior doctor. The hospitalist also goes to one of four annual orientation meetings at the California headquarters. Among the items discussed in the phone and headquarter sessions: risk management, billing and coding, how to communicate in the medical record, and practicing as a team and team player.

There is also a three-part series called Optimizing Care that includes case studies and "tricks of the trade." For instance, one topic might be how to get a stroke patient ready for rehab. "It is not the medicine part, but the healthcare system part," explains Gorman. "We help them to learn the maze and become experts on topics like what Medicare covers and what they do not."

New hires get their telephone modules over in the first month. Some of them may do their orientation trip to California before they start, others after. The company does try to space the information out. "If you squeeze it all in over a short period of time, you risk overloading them," she explains.

While the program is reviewed annually, not much has changed. "Resident education still doesn't include this kind of broad knowledge that we give," says Gorman. "The challenge we have that we constantly think about is how to make it clever. Making it case-based helps. We also try to tailor the sophistication level based on to whom we are talking." In the future, IPC may move to a two-tiered orientation program -- one for physicians with some experience, and another for new physicians. As to the latter, Gorman says you can assume that they know nothing more than picking the right antibiotic. They do not know anything about the health care system or health care economics.

Spoiled by familiarity?

While orientations are important, they are not a substitute for getting to know a facility really well, says **David Meltzer**, MD, PhD, associate professor of medicine and director of the hospitalist program at the University of Chicago Hospitals. "But you still have to do them. The trick is that if you do them well and keep your doctors happy, you will not have to do as many."

Meltzer, whose program is about to add a fifth hospitalist, says he's been lucky in that most of his hospitalists over the years have come from the University of Chicago, so they have knowledge of the institution. It has been three years since a hospitalist new to the institution started at the University of Chicago Hospitals, "and that person went to med school here, so she knew the institution. Last year, we hired the chief resident."

But more change is afoot: Meltzer is starting a fellowship program that will have several hospitalists from places other than the University of Chicago starting. "I think we are going to have to look at our orientation process again. I think we'll have to be more formal than we have been."

Indeed, there is a danger with having mostly hospitalists who know your facility. At Nanticoke Memorial Hospital in Seaford, DE, a new four-person hospitalist service started on Sept. 1. The medical director of the service --

Nanticoke Inpatient Physicians orientation program components

Early orientation process

- Appointment with human resources, including obtaining a name badge, benefit package, pre-employment physical
- Credentialing packages for insurance carriers
- Professional liability application
- Arrangement of professional photograph and biographical information for hospitalist brochure
- Ordering hospitalist lab coats

Later orientation process

- Tour of Nanticoke Memorial Hospital with introductions to key staff members
- Introduction to hospitalist service staff
- Review of policies with medical director
- Review of job description with medical director
- Appointment of a senior hospitalist to act as mentor during introductory period
- Participating physician office visits
- Introduction to dictation system
- Introduction to phone systems
- Introduction to computer systems
- Parking stickers
- Beepers/introduction to paging system
- Use of in-house portable phone
- Office orientation: office equipment, billing system, CPT and ICD codes
- Review of participating physicians list with review of other referring doctors

Source: Nanticoke Inpatient Physicians. Seaford, DE. Used with permission

Nanticoke Inpatient Physicians -- **Robert Ferber**, MD, had an orientation program in place from the start. He even appointed a physician to act as mentor during the introductory period. (For a list of what is included in the orientation program, see page 139.).

But less than three months in, he knew the orientation program was flawed: three of the doctors had privileges at the hospital previously. "Their orientation was focused on the hospitalist role -- that was the only new part for them," Ferber says. "The fourth physician did not start until October and was new to this hospital, but experienced in the hospitalist role. We found that our orientation for her has really been deficient. The biggest problem seems to have been that the physicians who have worked in this hospital are completely used to a variety of rather idiosyncratic 'the way things are done here' -- so much so that we didn't think of these kinds of things as part of orientation.

"Yet in retrospect, they are obviously important to a new person. In fact, we are asking our latest orientee to make a list of those things that should have been included, so we do it better next time. In the meanwhile, we are finding that the key thing is keeping regular and frequent communications between the hospitalists a part of every day, so that someone is always available to help out," Ferber says.

Having experience in a facility and in medicine in general certainly means that some of the things that Gorman would include in an orientation wouldn't be required at a place like Nanticoke or the University of Chicago Hospitals. But Meltzer thinks a period of co-attending is important for any new hospitalist, regardless of their previous experience. He did a month when he started. "I would like to see at least a week of it for our physicians," he adds, admitting that co-attending is not mandated to last that long currently.

Whatever program you decide on -- and Meltzer says you must have one -- you should make sure that everything you say verbally is complemented with written materials. "If you tell them who the good information sources are, hand them a piece of paper with that number. Show them a flow chart that illustrates patient flow. Give them a list of the names of the social workers, nurses, and others with whom they will interact clinically."

Hardest lessons not medicine-related

Perhaps the biggest -- and maybe hardest -- lesson for new physicians is that they have to learn about things that do not relate to patient care. If you work in an academic facility, provide orientation to teaching and research responsibilities to your new staff. "Introduce them to the critical administrators who play a role in shaping systems, like the head of the resident program and others who might be mentors to them."

Like IPC, Meltzer regularly reevaluates the orientation program and looks for new information that incoming hospitalists might need. "Systems change. We have attending briefing and debriefing sessions to go over issues and orient staff -- new and old -- to the changes."

One last tip: If your program is new, Gorman says you should be able to get considerable help developing an orientation from the hospital. The case management director would probably be happy to talk about DRG, HMOs and how the hospital gets paid. "You do not have to do this alone."

Editor's Note: Contact Mary Jo Gorman at (800) 724-0640; David Meltzer at (773) 702-0836; and Robert Ferber at (302) 629-6611. ☑

Just being there is a good start

What nurses really think about hospitalists

Endearing yourself to a nurse can be really easy: just be there. Indeed, if there is one message that nurses around the country want hospitalists to hear, it is that their availability has made them hospitalist converts. They really didn't need that much convincing. Tell a nurse that she will not spend half her day leaving messages, paging physicians, and hoping for a call back and you might as well have strewn rose petals down the hall for her to walk on.

"Being able to reassure the patient and family that someone is always available has been great," says **Betina Ponnoosamy**, RN, BSN, a charge nurse in the spine unit at Swedish Medical Center in Seattle. "From my perspective, it is even better. I know if a patient is going downhill quickly, I can get someone right now. Five years ago, I'd call a doctor and have to wait for a call back. Now, I know that if there is a crisis, the patient is taken care of."

While most of her orthopedic patients do not use hospitalists regularly, they are a factor in her work life. Perhaps her only criticism relates to what may be a flaw specific to the Swedish system. "I can't call the hospitalist

directly," she explains. "I have to call the provider in charge, wait for a call back, and tell them I think they need to get the hospitalist involved because there is a medical issue that needs to be addressed. They often tell me to call for them, but I can't. They have to make that call." That additional step can also add time.

Another thing on Ponnoosamy's wish list: a hospitalist who is dedicated to the orthopedic unit. That may happen when Swedish builds a new stand-alone orthopedic hospital.

Lastly, she would like to see better information available for patients about the hospitalist service. "If there is an explanation in the literature we give to patients, I wonder if they read it and understand it. I think that education on what a hospitalist is could be improved for our patients."

Along with the "being there" factor for patients, the amount of time hospitalists spend in the facility compared to some specialists means that often the hospitalist knows the nurses better than other physicians. That knowledge brings a trust and respect that can be lacking in the physician-nurse relationship.

Familiarity breeds trust

"I think the relationships are stronger and the confidence is greater because of the familiarity," says **Nancy Perovic**, RN, BSN, Quality Improvement Coordinator for the hospitalist program at the University of Chicago Hospitals. "We know each other's ways better. When you work with a hospitalist program, the feeling is more like what you get in an ICU or in the emergency department -- a real feeling of team. Things become faster and more streamlined."

The rapport extends to ancillary services, too, she adds. "And they know because of their familiarity with this facility and the system where the resources are. They are proactive, creative, and willing to make changes. That's something you do not usually see in a group of physicians. They will combat system issues and administrative obstacles to do what is right for the patient."

Perovic says she also appreciates their knowledge of the healthcare system. "They have this mind set about system issues and act when they see a problem," she says. For instance, sometimes labs do not get done for a variety of reasons. "If you have an attending who is only on service for a month or two out of the year, they will be in survival mode. They will opt to tax the system by making stat orders. Interns will find work-arounds. A hospitalist will find out what the system issue is that is holding up the lab work and collaborate to fix it. They do not just leave the problem as a note on a manager's desk. They work on finding a solution."

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The only criticism Perovic has is that she wishes hospitalists recognized how much nurses know. "The nurse is a pivot that hospitalists should make more use of," she says. "We should participate more in the plan of care. This would make their jobs easier, and I think it would translate to other services that often follow the hospitalists' lead."

She would also like changes in rounding procedures. "I would like to see multidisciplinary rounding, with times structured so that the most people can participate," she says. "If we had a better rounding program in place, every team member would know the plan at the same time."\

The waiting game is over

Up in South Dakota, the nurses at Sioux Valley Hospital in Sioux Falls love how fast the hospitalists provide care. "The indefinite waiting is over," says **Marie Rogers**, RN, MSN, a case manager at the hospital. She also likes the familiarity they have with the facility and the staff. She does occasionally worry about continuity of care. If a patient comes from outside the area, the hospitalist may not have the complete picture of that patient's health. Then again, she says, in the old pre-hospitalist days, the attending wouldn't, either.

Jill DeVries, another case manager at the hospital, also sings the praises of hospitalists in general. But she does have one suggestion: figure out a better way to balance the needs of critical patients and those who are not as ill. "The less complicated patients are seen last,

which is understandable. But those are the patients who are waiting to go somewhere, waiting to be discharged. There has to be a better way of rounding so that the more stable patients are not left without disposition."

"If you have two hospitalists on in the day and both spend most of their time with the more critical patients, maybe you should split it up, so that one is seeing the med/surg patients and one is doing critical care patients," says Rogers.

DeVries would also like to emphasize the need for having impeccable hand-offs between shifts. "Keep a thought to continuity of care and make sure you provide the best information in your sign outs," she says.

Lastly, consider adding nurses to your satisfaction survey lists. Most nurses love hospitalists and what they do, but they may also have great ideas. Consider asking them, says Ponnoosamy.

Editor's Note: Contact Betina Ponnoosamy at (206) 386-6000; Jill DeVries at (605) 328-2833; and Nancy Perovic at (773) 834-5983. ☑

New recommendations for CAP and HAP

Hospitalist-specific pneumonia pathways now available

Although hospitalists probably deal with a lot of pneumonia cases -- both community and hospital-acquired -- most do not follow any set guideline in treating it, says **Alpesh N. Amin**, MD, MBA, FACP, executive director of the 15-physician hospitalist service at UC Irvine Medical Center.

"Standardization of care differs from place to place," he says. "That is partly because so many different people are involved in community acquired pneumonia -- pulmonologists, cardiologists, primary care physicians." Hospitalists are ideally placed to develop, implement, and disseminate algorithms designed to improve care for the problem, he says. So he and his team developed one. The results of his effort were published in November in a supplement to *Current Opinion in Pulmonary Medicine.*[1]

"It is more than giving the right antibiotic," he says. "It is about ensuring that every patient gets a pneumo vaccine, that blood cultures are started before starting patients on therapy. This is the number one cause of infectious death in this country. Since we as hospitalists will be managing most of the cases, so we should be the ones developing the pathways to ensure that it is managed appropriately."

His hospitalist-led initiative is based on a consensus from hospitalists around the country. Amin put it in place at UCI Medical Center in 1998. He brought in case managers, administrators, infectious disease physicians, and pulmonologists and through grand rounds educated everyone from primary care physicians to pulmonologists. It worked: between 1999 and 200, length of stay for CAP declined by two days. Profits on these cases increased by between $500 and $700 per case. At the same time, an independent group looking at 30-day inpatient mortality at hospitals around the state found that during that 1999-2000 period, UCI had the lowest mortality rate in the state.

The pathway looks at everything from prevention to admission, treatment, and discharge. Among the recommendations:

- Posterior-anterior and lateral chest X-rays are a must. But avoid portable X-rays because of potentially inferior quality.
- Get sputum cultures only if there is someone available who can obtain, process, and interpret Gram stains in a timely manner.
- Know the patient's recent history of antibiotic use. Do not represcribe any antibiotic used in the last three months.
- Consider oral antibiotics if the patient can tolerate it.
- Initiate antibiotics within 4 hours of admission
- Consider how well the patient can care for him or herself when planning discharge.

The supplement also includes a pathway for hospital acquired pneumonia. Among the recommendations in that algorithm:

- Be aware of local and institutional resistance patterns.
- Investigate the patient's previous antibiotic use
- Assess the appropriateness for monotherapy and/or short-course therapy.

Maybe this all seems intuitive when read, but Amin says that hospitalists need this education. "We treat most of this. We are the people who need to know this first. But we also have to educate other physicians about this, too. We may manage 50 cases a year, but the primary care physician will still deal with a couple."

UCI is actually looking at their pathway again. Amin calls what he developed a "good template. It hits on points that institutions should think about as they develop their own guidelines. Your antibiotic choices may differ. You may

not agree with me about when to do the IV to PO conversion or what studies to do before you start antibiotics. But this has all the components of a good CAP pathway, and we've proved here that it works well for patients and for the hospital."

Editor's Note: Contact Alpesh Amin at (714) 456-3785.

Reference

1. Amin AN, Feinbloom D, Krekun S et al. Recommendations for management of community- and hospital-acquired pneumonia -- the hospitalist perspective. *Curr Opin in Pulm Med* 2004, 10(Suppl 1):S23-S27. ☑

NEWS BRIEFS

Here's help for breaking bad news to patients

Isn't it great when a lab test comes back negative and you do not have to tell a patient he has cancer? It is the other times, however, that try a physician: how to be compassionate and clinical at the same time. But a new review article in *Hospital Medicine* provides help for doctors.[1]

It used to be that patients might not be told bad news for fear it would actually cause harm. In some cultures, there is still a taboo against it. But there is actually research that shows that getting good information about one's condition reduces anxiety and depression. That can only be good news for treatment.

But how do you do it? The study looks at two different protocols, the SPIKES and the ABCDE mnemonic.[2,3] The advice from the two overlaps. Both suggest giving a warning to the patients. SPIKES suggests something like, "This is more serious than we thought." Both also warn against using jargon and finding out just how much detail the patient wants about test results and the condition involved.

ABCDE and SPIKES emphasize allowing for the patient to express emotion and providing empathy to the patient. They both also suggest offering realistic hope.

The article provides some resources for physicians, including a British website, www.breakingbadnews.co.uk, and one at the University of Washington, http://eduserv.hscer.Washington.edu/bioethics/topics/badnws.html. The article also includes practice scenarios.

References

1. Mir NU. Breaking bad news: practical advice for busy doctors. *Hosp Med* 2004 Oct;65(10):613-5.

2. Baile WR, Buckman R, Lenzi R et al. PIKES -- a six step protocol for delivering bad news: application to the patient with cancer. *Oncologist* 2000;5(4):302-11.

3. Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. *West J Med* 1999 Oct;171(4):260-3.

Hospitalists better than non-hospitalists for LOS

By now it shouldn't seem surprising, but another study has shown that when it comes to keeping length of stay down, hospitalists do better than non-hospitalists. According to the study in the November issue of the *Journal of General Internal Medicine*,[1] this holds true even when adjustments are made for the age of the patient, how recently the physician graduated, and the volume of patients seen.

Rifkin and associates looked at more than 11,000 admissions, 2,027 seen by hospitalists, more than 9,300 by non-hospitalists. Hospitalist patients were on average about 10 years younger than the patients of their non-hospitalist counterparts, and the study found that for each additional year of patient age increased the likelihood that the length of stay for that patient would exceed the average. Unadjusted or adjusted for this factor, hospitalists still were less likely to exceed the average length of stay. The affect was significant, with hospitalists reducing the likelihood of above average LOS by about 49%.

Why this is so isn't known, and the authors hope further research can identify what practices account for this.

Reference

1. Rifkin WD, Holmboe E, Scherer H, Sierra H. Comparison of Hospitalists and Non-hospitalists in Inpatient Length of Stay Adjusting for Patient and Physician Characteristics. *J Gen Int Med* 2004;19:1127 --1132. ☑

New special report offers detailed guidance on predictive modeling

National Health Information has just released a timely new special report providing detailed guidance on the use of predictive modeling in disease management and other health-related applications.

Predictive Modeling in Disease Management: Trends, Tools, and Strategies contains 150 pages of the latest information on predictive modeling systems, applications, results, and technology issues. Its 44 articles cover dozens of vendors, product comparisons, and real-world applications of this dynamic and increasingly mandatory technology solution.

The report is divided into three sections:

- **Trends and Technology**, featuring new modeling techniques designed to enhance accuracy; how predicting modeling is being used to enhance ROI; comparisons of modeling tools and technologies;
- **Product Profiles**, highlighting a dozen different predictive modeling programs; and
- **Case Studies**, detailing some of the most successful applications of predictive modeling technology in the real world of disease management and health improvement.

This must-have resource is available for $139 plus $5.95 shipping and handling. To order, go to www.nhionline.net, send your order to NHI, PO Box 15429, Atlanta, GA 30333-0429, or call 800-597-6300. All orders must be prepaid and are protected by NHI's 100% money back guarantee. ☑

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