New Ways to Support Specialty Inpatient Services

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IN THIS ARTICLE...

Examine how hospitals and specialty groups can design financially efficient alternatives to traditional practice models while maintaining high-quality tertiary services.

Recent changes in the aveailability of house staff coverage are having major effects on the inpatient practices of specialty groups.

In the past, specialists in tertiary care teaching hospitals relied on house staff to aid in the care of patients admitted to specialty-services. This help included management of non-specialty-related co-morbidities, help with admission and discharge paperwork and response to routine inpatient care needs (particularly during off hours).

In return, house staff freed time for the specialty physicians to teach while producing revenue for their patient care activities. Hospitals have found it difficult to provide an adequate and cost-effective replacement for the traditional house staff system.

Attempts that have been made include hospital employed hospitalists, private practice hospitalists, night coverage by temporary (moonlighting) physicians and mid-level provider use. Specialists have become more resistant to maintaining inpatient services and have transitioned to primarily in-hospital consultative work.

Without adequate coverage, specialists are reluctant to admit patients to their services. This has resulted in a potentially less-efficient style of care for patients admitted to tertiary care hospitals with primarily a specialty-related condition or diagnosis.

Rather than the appropriate specialist determining the initial plan for diagnosis and treatment, a generalist takes on initial responsibility. The specialty service may then be called in for consultation. The result may be initial inappropriate, costly diagnostic studies and a delay in discharge timing.

In addition, the tertiary care image of the hospital may suffer in both the eyes of the patients and those of the external referring physicians. Specialty physician dissatisfaction with hospital administration also develops and may lead to a change in favored hospital use.

Hospitals have an interest in maintaining their tertiary level services for several reasons.

- Most tertiary level cases offer a relatively high reimbursement opportunity along with a significant margin. A decrease in these admissions would have a significant impact on a hospital's financial condition.
- Providing tertiary services enhances the reputation and stature of a hospital and thereby helps to maintain general patient flow, both on the inpatient side as well as on the lucrative outpatient side.
- The reputation of the hospital, including that enhanced by the provision of specialty services, increases its desirability to physicians seeking medical staff affiliation (thereby adding to its admitting physician base). Access to insurer networks may also be improved by the availability of a larger range of services.

As a result hospitals have an interest in promoting specialty, particularly tertiary level, services. Rationally dealing with the needs of specialists is therefore an imperative.

Criteria for solutions

Any proposed solution to this need for specialty physician support would have to meet several criteria based on the needs and limitations of both the physicians and the hospital organizations. These include, but are not limited to:

- The level of the quality of care resulting from any new arrangement must be the same as or higher than the

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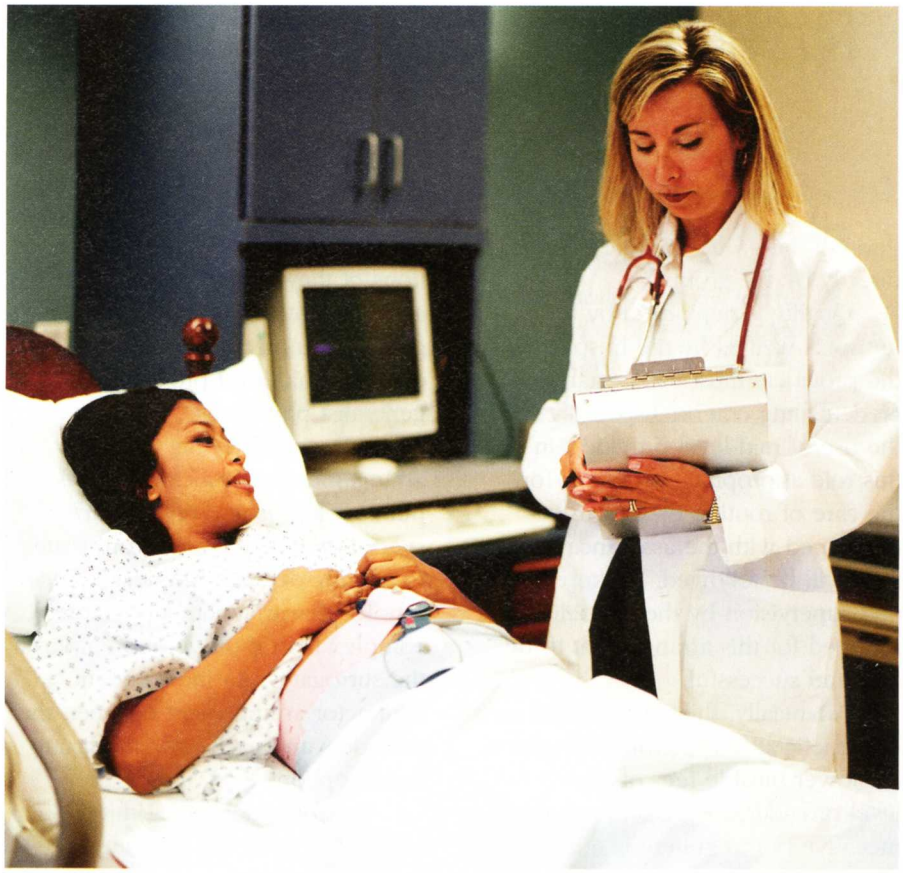

present situation. Alternative rounding and call coverage arrangements frequently utilize mid-level providers or non-subspecialty physicians. A system that involves these alternative providers must ensure that the admitting specialist level of quality is maintained.

- Any alternative solution must be financially sound. Neither the hospital organization nor the involved physicians should unduly suffer as a result of the arrangement. In designing the new system both hospital-employed and physician-employed models should be considered.
- The new arrangement must meet health care law requirements. Solutions that can be inferred to involve inurement, pay-for-referral or other illegal situations should not be considered.
- As much as possible, the arrangement should maintain the independence of the private practitioner or group. However, due to the legal restrictions imposed on both hospitals and physicians some partial employment relationship for the specialists may have to be considered.
- Adequate and appropriate communication among all parties is critical. Expectations regarding communication between the specialist and the coverage surrogate (mid-level provider, generalist physician, etc.) as well as between the surrogate and the hospital staff must be clearly outlined.
- Finally, the arrangement must be "customer friendly" to all parties, but particularly the patient and the referring primary care physician. Availability of the covering provider to the patient and to the referring physician as well as a clear understanding of the roles by all parties must be an understood requirement.

Possible models

There are no "one size fits all" solutions to the present problems confronting tertiary care organizations. Any arrangement will have to be adapted to the local situation and attempt to meet the criteria.

Employment by specialty groups

This is the simplest arrangement to develop, as legal issues regarding the physician-hospital relationship are not involved. However, the financial sustainability of this model generally requires a relatively larger physician group.

Under this model mid-level providers or, less frequently, generalist physicians provide in hospital coverage night and day for the specialists in the group. Coverage of off-hour calls from non-hospital patients is usually included. Services rendered by these surrogates are billed

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through the group and they are paid directly by the group.

Quality is monitored by the group as well as by the hospital and the providers must meet established credentialing criteria. Especially with the use of mid-level providers in this role appropriate protocols for the care of routine issues can be developed with the assurance that they will be followed. Backup call and supervision by the specialist are required for this arrangement to be safe and successful.

Financially, this arrangement can be beneficial to the group (despite the lower billable fees of mid-level providers), especially when an incentive bonus system is utilized to ensure reasonable productivity.

Additionally, when adequate independence is given to these providers, specialist physician time is freed to provide other potentially higher level billable services during usual business hours. The employment of generalist physicians may require a larger group size to be sustainable.

Adequate communication regarding the arrangement with referring physicians and patients with reassurance regarding the involvement and availability of specialist physicians is required. Appropriate training by the practice in both appropriate care of the patients and expectations regarding relationships with the hospital staff, patients and referring physicians is mandatory.

Limited multispecialty employment

This model is similar to the above but makes the employment of specialist surrogates a financially viable option for smaller groups. Employing the criteria and conditions of the previous model, this arrangement may involve specialty groups sharing the expense of coverage by mid-level providers or generalist physicians.

It is suited ideally for an arrangement among cardiologists, pulmonologists and critical care specialists where patient care issues frequently overlap. The legal structure for this arrangement is more complex than if one group employs the surrogates. An independent contractor arrangement between the providers and each specialty group is one option.

The formation of a Limited Liability Corporation that employs the providers, bills for their services and returns margin to the LLC members is another. Multispecialty groups can employ this model in the same way as the previously described arrangement. Specific subspecialty oversight and training are necessary to ensure that this model fulfills all the desired criteria.

Independent hospitalists

Hospitalists have formed private practice model groups (in addition to the hospital-employed model.) Specific specialty group admission arrangements are practical between either a subspecialty group, or a limited number of groups, and a hospitalist group.

Under this arrangement patients are admitted to the hospitalist group at the request of the subspecialist. Appropriate consultation with the subspecialist is made based on the presenting complaint or diagnosis. Advance protocols can be developed so that the hospitalist group orders appropriate testing and therapeutic modalities, thus essuring quality and cost effectiveness.

The hospitalists bill independently as do the subspecialists. Communication with patients and referring physicians clarifies the role of each type of provider. Final communication to the referring physician by the specialist ensures adequate follow-up and solidifies long-term referral relations. No potential physician-hospital legal issues are involved.

An alternative arrangement involves admission of patients by the specialty group with consultation of the hospitalists for non-specialty related problems. Agreement regarding off hours coverage would then have to be made in order to satisfy the specialists' concerns. Coverage of outpatient issues is not easily resolved in these models.

Hospital-employed coverage

Hospitals can employ mid-level providers or generalist physicians and assign them to specific inpatient specialist coverage. Under this model, the hospital employed provider may provide "free" service to the patients on behalf of the specialist or the hospital/provider may bill for services.

Providing 'free" services may raise inurement issues with not-for-profit entities, especially if the work done by the hospital-employed provider is used for billing purposes by the specialist. These services obviously are an expense to the hospital that must be justified both from the legal and the financial standpoints.

If the work of hospital-employed providers is not used

for billing purposes by the private practice physicians this arrangement is feasible. Specialists would then act as consultants as noted above. A benefit of this arrangement is the accountability regarding hospital issues such as length of stay, decreased use of services for DRG payment patients and potentially less overall expense compared to a similar arrangement with non-hospital-employed hospitalists.

Partial specialist employment

To overcome the above issues a more complex alternative involves employment of the private practice specialists for the time they are caring for patients in the hospital. This allows the work that hospital-employed mid-level providers perform to be included with the work that the specialist performs for billing purposes, easing the burden of caring for specialist admitted inpatients without fostering the legal issues mentioned previously.

Under this model the hospital would bill for the specialist services and pay the private practice group, probably on an incentive basis. For other work the specialist group would remain in a private practice model.

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