The tenets that govern the very nature of hospital medicine have now infiltrated the health care industry as a whole. Hospitalist groups, hospitals and health systems, and insurance and government payers are, in different ways, asking physicians to provide more efficient and higher quality care. And the kicker: It directly impacts your paycheck and the future financial success of your organization.

Pay for performance (P4P) may already be part of your working life. If it isn’t, it will be soon in several ways:

• Your group will likely make some of your remuneration dependent on achieving certain goals -- both clinical and administrative.
• Your hospital may include meeting certain performance goals part of your group’s next contract.
• Payers are increasingly asking hospitals to achieve certain clinical goals, and in the future, they are likely to reward those who do with bonuses, and punish those who do not with lower reimbursement. While some might think this latter version of P4P will only tangentially affect hospitalists, they are wrong. As leaders in the hospital who are intricately linked to quality improvement, the weight of leading efforts to meet those goals will likely fall largely on inpatient specialists.

For hospitalist groups developing P4P programs for their physicians, one chief difference in the latest incarnation is that the goals look a lot like what hospitals are being asked to deliver by payers, often focusing on high-volume DRGs and relying on evidence-based principles. They are often the focus of efforts at the national level by groups such as the Centers for Medicare and Medicaid Services (CMS) or the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). Martin Buser, a partner in the hospitalist consulting group Hospitalist Management Resources, based in Del Mar, CA, says an example might include elements such as these, taken from actual hospitalist contracts:

• A hospitalist group caring for patients between Jan. 1, 2006 and Dec. 31, 2006 with a diagnosis of congestive heart failure (DRG 127) and meeting the inpatient criteria will follow CHF clinical guidelines, and prescribe ACE inhibitors upon discharge (per documentation in the medical record). Any practice variance from the above will require the basis for exclusion to be documented in the medical record 95% of the time.
• For the period of Jan. 1, 2006 to Dec. 31, 2006, the hospitalist group and hospital will develop a methodology to track and assign avoidable days. They will mutually agree on a definition and target for reduction in the hospitalist group’s assigned avoidable days, and achieve over 95% of target the first year of the program.
• The group will develop and implement, in collaboration with the hospital and network, clinical guidelines for DRG 88 -- chronic obstructive pulmonary disease -- and DRG 294 -- diabetes age > 35. The hospitalist group will update and follow the clinical guideline for DRG 89 -- simple pneumonia/pleurisy > 17 with CC. Any practice variance from the above will require the basis for exclusion to be documented in the medical record 95% of the time.
Steven Nahm, vice president of the Camden Group, has helped set up several hospitalist incentive programs. They are most often based on a combination of quality and service indicators. By and large, hospitalists have been very open to them.

“Their biggest concerns are whether the hospital has a good enough tracking and reporting system and whether there is an adequate patient base for the quality indicators to be statistically significant,” he explains. Another concern is whether the P4P system will be individually based or not. While making it specific to individual hospitalists might seem the most logical thing to do, Nahm says group performance is the best thing to measure. “That’s because hospitalists hand off patients to each other at least once per day. They don’t work 24-hour shifts.” In addition, hospital medicine is a team effort, and to raise the bar on quality, you have to reward the group, not individuals. There are some ways to achieve individual rewards, but not for those based on patient care, says Nahm.

**What should be rewarded?**

The biggest issue in developing a group P4P program is deciding what to reward. “You have to sit down as a group and analyze the process of care given to certain types of patients: CHF, back pain, whatever,” says Nahm. “You have to decide as a group how you will handle these types of patients and come up with a generally expected length of stay.”

Whatever you decide to look at, you should not assume those parameters will stay in place indefinitely. Nahm recommends re-examining them every year. This year, it might be diabetes, pneumonia, and CHF. Next year, it may be different. Look at what the state, CMS, and various quality organizations are looking at. Recently, Nahm worked with a group that wanted to use the national patient safety guidelines from JCAHO as a starting point in determining what indicators should be the focus for the coming year’s P4P program.

At Cogent Healthcare, physicians’ bonus programs are tied closely to the quality needs of the hospital in which they work, says Ron Greeno, MD, chief medical officer and one of the founders of the hospitalist company. “Since our programs are hospital-centric, we have to make sure the rewards we give to our physicians are based on things that also benefit the hospital in terms of quality and efficiency,” he says.

Along with quality issues, physicians are also rewarded based on service items such as how quickly they provide discharge summaries to primary care physicians, and growth of the program.

While rewarding the group is important, Greeno says it is also important to reward individual physicians. Unlike Nahm, he looks for metrics in areas of focus that can be tied directly to a particular physician and uses those as part of the physician P4P program.

“By nature, hospitalists represent a team,” he says. “We use patient satisfaction as a team metric. But for things like timeliness of communication, we can attribute that directly to a particular physician and it can also be verified reliably.”

Greeno worries about putting too many metrics in place for a program. He says you “can’t measure 10 things. If you do, it becomes a burden to administer. Instead, you pick a few very critical things. It can vary year to year, and from program to program.”

**Hospital demands**

Increasingly, hospitals are making demands of their hospitalist groups in terms of quality. Greeno says most hospitals think patient satisfaction and timeliness of communication with the primary care physician are important and include those elements in contracts. “But we also include clinical metrics depending on the program,” he says. “A significant proportion of the revenue of this company is at risk based on our performance on those measures. But it will vary from hospital to hospital.”

Whenever it can, Greeno says Cogent will tie those clinical measures wanted by the hospitalists to the P4P program in which its physicians participate. If possible, they try to tie it to individual hospitalists. “But if you have a contract that requires we meet a certain threshold on doing three things for heart failure patients and two for pneumonia, we can’t always do that,” he says. “With pneumonia patients, if you want to meet certain timeliness in the delivery of the first dose of antibiotics, there is more than just the hospitalist involved in that. Pharmacy, the emergency department, nurses -- they all have a role. A single hospitalist can do a great job and not meet that particular goal through no fault of his or her own. But we can measure whether heart failure patients go home with an ACE inhibitor -- we can tell from the discharge note if that happens, and that can be...
directly attributed to the physician who writes that note.”

In a way, hospitalist incentives that are built into or driven by hospital contracts can be viewed as an example of the trickle down theory applied, says Nahm. “A hospital can be penalized or paid additional sums based on how they perform, so they are asking hospitalists to meet certain goals,” he says. The dollars at risk for a facility are grand: Medicare estimates that performing at bonus level will mean a 2% difference in reimbursement. If a typical hospital has margins of 4% to 5%, and Medicare is half their income, the impact could be massive, he says.

**Take an active role**

When your hospital starts making P4P an issue, it’s key that you schedule a meeting with hospital executives to agree on goals and expectations. That group should include the director of quality, the director of case management and/or utilization management, the vice president of medical affairs, and the director of inpatient services.

Nahm’s group usually runs an analysis on the high volume admissions for the hospitalist group and compares how the group is doing from length-of-stay and resource consumption standpoints, as well as how their standard of care compares to existing quality measures. “If we see something that has room for improvement, we choose that,” he says. “Pick the low hanging fruit first.”

Hospitalist participation in these hospitalwide programs also is part of their individual bonus programs, accounting for as much as 30% of total compensation. In other instances, hospitalists are rewarded for participation on key hospital committees that impact quality and are required to address processes of care for specific DRGs that might have an impact on achieving hospitalwide goals.

Groups that are sponsored and receive hospital subsidies are generally already addressing these issues, Nahm says, in part at the instigation of the hospitalists themselves. “Those who go to the meetings and are members of the Society of Hospital Medicine believe in the values of hospital medicine -- quality, leadership, and team. It’s more than just good bedside clinical care. You can have a large impact on the success of the hospital itself.”

Even hospitalists who are employed by the hospital can get involved in these kinds of projects as a way to show their continued added value. Along with the chance to perhaps get more out of their next compensation negotiation, Nahm says those hospitalists may find improved job satisfaction. “Having standards you are trying to achieve makes your job more interesting,” he says. “It adds an element to your job and gives you a chance to be recognized for doing superb work.”

**The payers’ turn**

Buser notes P4P is going to be increasingly “high stakes” for hospitals. “If you have a facility that isn’t hitting 100% compliance with the relevant DRGs, then they will be out of the bonus game. To achieve the top 10% that will get those Medicare bonuses, you will have to be perfect.”

Failure will not be an option, Buser adds. “You will have to set the quality bar for the entire medical staff.”

There are several models of payer P4P currently being piloted. In Orange County, a group of California health plans launched a groundbreaking program in 2002 with select performance measures and corresponding physician bonuses. Another program in Boston looks at both quality measures and cost containment efforts. These are primarily practice-based rather than hospital-centric. The Center for Studying Health System Change published a report outlining some of these efforts. ¹

*Health Affairs* devoted part of its January/February issue to the potential impact on hospitals of P4P systems.² It reported on the Premier Hospital Quality Incentive Demonstration, in which 268 hospitals in the Premier group of non-profit facilities participate. The others examine the effect of P4P incentives and penalties on those hospitals. The group is measuring performance in evidence-based measures for heart attack, CHF, pneumonia, CABG, and hip and knee replacement surgery.

The best-performing hospitals are eligible for bonuses, with the top 10% getting a 2% bonus, and those in the 80th-90th percentile getting a 1% bonus. Those who perform below the 10th percentile are penalized 2%, and those from the 10th-20th percentile are penalized 1%.

CMS also is running a pilot project for 10 large health care organizations that will provide bonuses when goals are met for 32 different metrics on issues from diabetes care and disease prevention efforts to CHF care.

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One of the participating groups is Geisinger Medical Center in Danville, PA. “Hospitalists play a reasonably important role in the care of a large number of patients,” explains Ron Paulus, MD, MBA, chief healthcare IT venture officer for the hospital. Being part of the demonstration project has impacted the entire health care system -- inpatient and outpatient -- because it demands enhanced coordination of care. In the inpatient setting, it has been further impetus to invest in technical services and has led to even more efforts to reward quality care.

For example, Paulus explains, the hospital is setting up a pilot project that would bundle episodes of care in the acute care setting. For coronary bypass patients, the pilot requires Geisinger to guarantee they will comply with each one of 14 separate evidence-based standards -- such as using aspirin in CABG patients and ceasing use of drugs like Plavix five days before the operation. “We will do all of those 14 things together, rather than checking the box for each individually,” he says. “If we do not do any one of those 14 things, then we are at risk for all complications and readmissions at no cost to the payer.”

A facility would be considered a top player if it did each of those 14 things 98% of the time. “But that gives you 14 different ways to miss,” Paulus says. “At the end of the day, we are searching for a way to be as close to perfect as we can.”

Greeno says he thinks the future will see the payer demonstration projects becoming widely implemented, and for that reason, hospitalists will eventually be in every single facility that wishes to meet those bonus goals. “If you are in an era of P4P, you have no chance of competing for those bonuses unless you have a highly functioning hospitalist program in your facility,” he says. “There are hospitals that will perform at the highest level. As hospitalists, our job is to make our hospitals successful. We should be rewarded for doing so, but we also have to remember that our future as hospitalists is inextricably linked to the future of our hospitals. If they succeed, we will, and it is part of our job to ensure that they do.”

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