LEADERS: DR. JOSEPH M. LI

Working to Improve Transitions of Care

At Beth Israel Deaconess Medical Center in Boston, Dr. Joseph M. Li and his team of 33 hospitalists are expanding the traditional role of the specialty, taking on more teaching opportunities and providing limited outpatient care.

Dr. Li, who founded the program in 1998 and serves as the director of hospital medicine, has been pushing the hospitalist team to do more than just the usual inpatient care duties. About 5 years ago, the hospital medicine program launched a procedure service. Now bedside procedures performed by house staff are supervised by a hospitalist, Dr. Li said.

"It's been a wonderful opportunity for us to teach the procedure and to supervise and make sure our patients get quality care," Dr. Li said. "We've found that it's also a wonderful opportunity for us to interact with house staff."

With the implementation of the procedure service a success, the hospital medicine program attempted to tackle the thorny issues of avoidable readmissions and continuity of care at discharge.

Last September, Dr. Li and his team launched a postdischarge clinic at the hospital. Due to the shortage of primary care physicians in the Boston area, Dr. Li and his colleagues found that after being discharged from the hospital, patients were waiting 4-6 weeks on average to get follow-up care with their regular physician. That's far from the 2 weeks Dr. Li said is the ideal window for follow-up care. And he has seen some patients return to the hospital with problems that might have been avoided if they had been seen earlier by their primary care physician.

When evaluating improvements in quality of care, 'you can't look just simply at the readmission rate.'

DR. LI

The goal in setting up the postdischarge clinic was not to create outpatient work for hospitalists, he said. In fact, the hospital's call center books the first available appointment with the patient's primary care physician as part of the discharge process. But when that appointment isn't timely, the call center staff sets up an interim visit in the hospitalist-run postdischarge clinic.

The experience has been a bit like looking in a mirror for the hospitalists, Dr. Li said. Now that they hand off their patients to one of their colleagues, they've learned that they don't always do as good a job in the transition of care as they previously thought, he said.

The launch of the clinic has created some confusion for patients, requiring some extra explanation from both the nurse and the inpatient hospitalist. It's also caused some confusion for primary care providers, some of whom initially wondered if the hospitalists were trying to poach their patients, Dr. Li said. "We had to make it very clear that we're going to make every attempt to have that patient follow up with you before we send the patient to the postdischarge clinic," he said. "That continues to be a work in process."

But some primary care physicians have been very receptive to the notion that someone can help provide the transition after hospitalization and potentially improve the care for patients. Primary care physicians "are awfully busy today trying to provide timely access for all their patients," Dr. Li said.

It's too early to tell if the effort is accomplishing the ultimate goal—to reduce unnecessary readmissions and improve quality of care. Dr. Li said they are reviewing data on the readmission rates of each of the hospitalists. However, it's complicated to tease out the impact of having a sicker patient population, as well as to determine the appropriate balance between the patients' length of stay and their chances for readmission. "I think that you can't look just simply at the readmission rate," he said. ■

By Mary Ellen Schneider

Hospitalists Brace for Challenges of Health Care Reform

BY DENISE NAPOLI

The health care reform law signed by President Obama last month clears the way for about 32 million previously uninsured Americans to get coverage in coming years, but the changes will bring new challenges for hospitalists, physicians told HOSPITALIST NEWS.

"We have long supported efforts to expand health care coverage to all Americans, and in that respect, this legislation is a step in the right direction," said Dr. Eric M. Siegal, chair of the Society of Hospital Medicine's public policy committee. "One cannot bring 30-plus million Americans into the system and expect costs to decrease if one doesn't also address the inefficiencies and perverse incentives that are driving health care costs ever higher."

Dr. Alpesh Amin, executive director of the hospitalist program at University of California, Irvine, agreed. "It's going to make the hospitalists much busier," he said in an interview. "Volume is going to go up," and that could pose a problem for a specialty facing a shortage of physicians available to fill existing positions.

Although health care reform includes a Medicare payment incentive designed to bolster the supply of primary care physicians, hospitalists will not be eligible for those bonuses, Dr. Siegal noted. Only services rendered in the ambulatory and nursing home setting will qualify.

Another concern: The new law does not address the sustainable growth rate formula that is used to adjust physician Medicare payments and that many physicians see as flawed. Under the formula, Medicare physicians' fees were cut 21% on April 1 as Congress—which has postponed but not eliminated the cuts for several years—adjourned for a spring recess without acting on the SGR. At press time, the Centers for Medicare and Medicaid Services (CMS) was holding Medicare claims for 10 business days until Congress could reconvene and address the issue, probably on a temporary basis.

"This is simply unacceptable," Dr. Siegal said. "If the government expects physicians to dramatically alter the way that we practice to deliver better health care, the absolute minimum that we should expect in return is a stable and predictable reimbursement methodology."

Hospitalists will be much busier as volume goes up, and that could pose a problem for a specialty facing a shortage of physicians available to fill existing positions.

Hospitalists could benefit from continuation of the Physician Quality Reporting Initiative. PQRI participants stand to receive incentive payments of 1% in 2011 and 0.5% from 2012 to 2014. Physicians who don't participate will be penalized starting in 2015. "The PQRI looks like it is here to stay," Dr. Siegal said. "We know that less than 20% of physicians currently participate, and hospitalists will obviously need to gear up to participate if they want to avoid being penalized."

Other benefits of the reform law relate to the discharge process, Dr. Amin said. "As a hospitalist, I'm discharging patients out of the hospital who may not have any good follow-up," he said. "And when they don't have good follow-up because they don't have insurance, there's a higher chance of readmission." Discharge without follow-up could become much less likely once an additional 32 million Americans get health insurance, he said. "If there's follow-up available, that's a wonderful thing. We'll be able to feel comfortable about putting patients back out in their community."

Dr. Patrick Conway, director of hospital medicine at Cincinnati Children's Hospital, agreed. "Decreasing the number of uninsured will benefit most hospitals and hospitalists," said Dr. Conway, a former chief medical officer at the Department of Health and Human Services (HHS).

Hospitalists will see more hospital-based demonstration projects focusing on quality, value, and comparative effectiveness research, he predicted. Also, a new Center for Medicare and Medicaid Innovation within CMS will test novel payment methodologies aimed at improving quality and reducing costs. "Hospitalists will play key roles in many of these programs," Dr. Conway said.

The health care reform law also aims to bring transparency to relationships between pharmaceutical companies and physicians and hospitals. Under the incorporated Physician Payments Sunshine Act, sponsored by Sen. Chuck Grassley (R-Iowa) and Sen. Herb Kohl (D-Wis.), makers of medical supplies, pharmaceuticals, biologics, and devices must report any payments or transfers worth more than $100 a year that go to physicians and hospitals, starting in 2013. Manufacturers also will have to report any and all physician ownership stakes. The HHS will be required to make this information available to the public.

Also, starting in 2012, manufacturers will have to report to the HHS all drug samples given to physicians, if the drugs are covered by Medicare or Medicaid.

Finally, the reforms establish an Independent Payment Advisory Board, which will recommend Medicare spending reductions whenever annual spending on Medicare exceeds a yet-to-be determined rate. Precise details about how this board will function remain to be addressed via federal regulation.

According to Dr. Siegal, that's no surprise. "A lot of the implementation of these bills is subject to interpretation by CMS," he noted. "The next 12-18 months will be phenomenally busy as CMS struggles to turn 2,000-plus pages of legislation into actionable statutes."

He added that "it will be absolutely critical for hospital medicine to be represented in this process, and for us to lend our expertise to ensure that we get the outcomes that are intended. Only then will we really know if the bills are likely to deliver." ■

INDEX OF ADVERTISERS