Some Hospitalists Wary of Bundling Proposals

BY JOYCE FRIEDEN

The concept of "bundling" of payments to physicians and hospitals has emerged as a potential element of health care reform, but some hospitalists are expressing concerns about the potential effects of untested bundling proposals.

Under at least one of the health care reform proposals being considered by Congress at press time, the Secretary of Health and Human Services would be required to "develop a detailed plan to reform payment for post acute care (PAC) services under the Medicare program." The plan is to consider, among other things, "the nature of payments under a post acute care bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services should be included in the bundle, and the period covered by the bundle."

Proponents of bundling say it would create a good incentive for hospitals to avoid readmissions by providing high-quality care, calling that an improvement over the current system, in which physicians get paid for every test or procedure they perform and hospitals get more money each time a patient is admitted.

But private-practice hospitalists—those who contract separately with the hospital—are concerned about how such arrangements would affect their revenues.

"Healthcare reform legislation holds the potential for a cataclysmic uprooting of the traditional fee-for-service payment system," wrote the authors of a white paper from the Phoenix Group, an organization of private-practice hospitalists. Reform might "leave hospital medicine in a position of vulnerability, particularly with respect to the security and reliability of compensation. No longer would even a portion of a hospitalist's revenues remain free of control by the hospital." (See www.phoenixgroupwhitepaper.com.)

'Depending on how you're reimbursed and how you structure relationships with hospitals, bundling has the potential to either be perceived as a positive or a negative.'

Dr. Eric Siegal, chair of the public policy committee of the Society of Hospital Medicine (SHM), said that recent surveys show that roughly one-third of hospitalists are employed by hospitals, another third work in academia, and the remaining third are in private practice. "Depending on how you're reimbursed and how you structure relationships with hospitals, bundling has the potential to either be perceived as a positive or a negative."

Bundling is "certainly worth exploring" as part of efforts to change the current "flawed payment methodology," said Dr. Ron Greeno, who is cofounder and chief medical officer of hospitalist firm Cogent Healthcare and a member of the Phoenix Group. "The way we're paying doctors and hospitals now isn't working. It's misaligned, creates waste, and [incentivizes] for the wrong things."

But bundling has not been tested enough to prove that it works, added Dr. Greeno, a member of the SHM's public policy committee. "There's no proof that [bundling] will lead to better care or less wasteful care. If it's going to be done, there needs to be careful consideration about how it's done, and they should try it a few places" before instituting it.

A key issue is how bundled payments will be administered, he said. "If there is a bundled payment, who is it going to go to? If you're dealing with a Kaiser or another fully integrated system, that's not a problem—it just goes to that entity. But for the average community hospital that doesn't employ physicians and has a volunteer medical staff, who does that payment go to? The hospital, most likely. Then the hospital has a bundled payment with no formal financial relationship with all the doctors that are going to take care of that patient. Are you going to negotiate a different arrangement with every single doctor on the staff?"

If the hospital has a hospitalist program in which hospitalists see 60% of the patients in the hospital, "that makes it a little easier because there is already a financial framework," he continued. "But those doctors need surgeons and cardiologists to help them, so they still have to work out arrangements with them."

Dr. Greeno noted that his company is already using bundling with some of its hospital clients. "We're pooling Part A and Part B [Medicare] dollars and using incentives for better care."

Any discussion of bundling must include the view of hospitalists, he added. "Any discussion that doesn't involve the hospitalists' point of view is probably not going to work, because in the future the vast majority of hospital care is going to be provided by hospitalists. That's a very important point of view they need to consider." ■

Advocacy Group Offers Free Quality Tool for Hospitals

BY MARY ELLEN SCHNEIDER

To help hospitals improve quality and reduce costs, the Institute for Healthcare Improvement has released a free online tool that allows hospitals to find best practices, assess performance, and design quality improvement plans.

The IHI Improvement Map includes best-practice information on 70 processes of care, 40 of which can help hospitals to control costs. "The improvement map is meant to be a resource that hospitals and their leaders, clinicians, and others can go to, to help them organize and make sense of their own improvement efforts in a very complex terrain as they try to improve quality and decrease costs at the same time," Dr. Donald M. Berwick, president and CEO of IHI, said during a webinar.

For example, a physician using the tool could seek information on preventing catheter-associated urinary tract infections. In addition to detailed information about that process, the map includes the cost, time, and difficulty involved with implementing the changes. It also provides information about the level of evidence to support the process.

More than 100 U.S. hospitals helped test a prototype of the Improvement Map and are already using it as part of their quality improvement projects, according to IHI, an independent not-for-profit organization focused on improving health care processes and systems. The organization began rolling out the tool more broadly in September, and interest has been strong. In only a few weeks, more than 8,700 people tried it out, Dr. Berwick said.

The Improvement Map focuses on quality information related to hospital processes of care, but IHI officials said they expect to expand the map to other areas such as ambulatory care and home health care.

The Improvement Map is already getting high marks from physicians and hospital officials. "This is a landmark resource that is going to help accelerate the activities of hospitals," said Stephen R. Mayfield, senior vice president for quality and performance improvement at the American Hospital Association.

The tool gives hospitals a place to start on quality improvement regardless of their size or financial resources or how many projects they already have underway, he said. It will also help hospital officials to choose projects that will give them the best return on investment.

Dr. Nancy Nielsen, past president of the American Medical Association, said the effort by the IHI is a great example of how to move forward on quality improvement, without waiting for the government to do so.

"These are things that we can take on as a health care community throughout the country and in fact throughout the world where we have influence," she said. ■

Value-Based Purchasing Demo Maintains Quality Improvements

BY BROOKE McMANUS

Hospitals participating in the Hospital Quality Incentive Demonstration value-based purchasing project funded by the Centers for Medicare and Medicaid Services raised their overall quality by 17% over 4 years, the agency reported.

The program, launched in 2003 by the CMS and Premier Inc., an alliance of not-for-profit hospitals and health care systems, is designed to test Medicare payment incentives. The goal is to determine if the incentives will improve the safety, quality, and efficiency of inpatient treatment of acute myocardial infarction, coronary artery bypass graft (CABG), heart failure, pneumonia, and hip and knee replacement. The CMS awarded $12 million in year 4 to 225 hospitals. The program determines average composite quality scores for the five areas using more than 30 evidence-based clinical quality measures developed by the Joint Commission and other groups.

In year 4, the mean score had improved most for heart failure patients and pneumonia patients. The heart failure score rose from 64.5% to 92.2%, based on measures that included evaluation of left ventricular systolic function and smoking cessation counseling. The score for pneumonia rose from 69.3% to 92.6%, with measures including appropriate initial antibiotic selection and influenza vaccination.

Hip and knee replacement scores rose from 84.6% to 97.2%, based on measures such as the use of prophylactic antibiotics and the 30-day rerate. For MI patients, the average scores improved from 87.5% to 96.3%, with measures for reporting including administration of aspirin and beta-blockers on arrival, and primary percutaneous coronary intervention within 90 minutes of arrival. According to Premier, the performance improvement saved the lives of an estimated 4,700 MI patients over 4 years.

The average score for CABG patients was up from 84.8% to 98.5%, based on measures that included the use of aspirin at discharge and inpatient mortality.

The shift to paying for health care based on performance rather than volume is often cited as a primary goal of health reform. The reform bills that have surfaced so far this year do not provide much detail on how programs like HQID could be expanded beyond the demonstration phase, although there has been attention to the processes for selecting and validating new quality measures. ■

Brooke McManus is a reporter for The Gray Sheet. This newspaper and The Gray Sheet are published by Elsevier.