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Hospitalist Pilot Model Sparks Controversy

Public backlash includes legal action to protect the interests of physicians and patients

By Jessica Bailey-Wheaton, Esq., and Todd A. Zigrang, MBA, MHA

A **PILOT PROGRAM** in two Naples Community Hospital (NCH) Healthcare System hospitals, where only NCH-employed hospitalists handle admissions and direct inpatient care ("The Hospitalist Model"), has sparked controversy within the Naples, Florida, community. The Hospitalist Model aims to foster a collaborative approach to in-patient healthcare through a hospitalist and support team in order to enhance patient-centered care and inpatient outcomes, congruent with the system's stated commitment to quality. However, patients and independent physicians have expressed significant concern regarding the potential disruption of the doctor-patient relationship that may occur upon the expansion of this model when a hospitalist controls in-patient care, rather than the patient's established primary physician.

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Geographic Rounding

The pilot, which initially began in June 2018 on one floor in each of the two NCH hospitals, recently expanded to a third floor, with the possibility of further expansion into a "closed, employee only" staff model throughout both of the hospitals. This model utilizes "geographic rounding," in which an employed hospitalist handles all medical admissions for a total of 18 patients in a designated area. The hospitalist makes rounds twice during the day, during the hours of 7:30 am to 5:30 pm, along with a support team (pharmacy, rehabilitation and ancillary services), prioritizing the patients most in need of care.

Under the pilot model, patients have the choice to either participate in the pilot program or be admitted and treated by their primary doctor (pending room availability on one of the nine nonpilot floors between the two hospitals). Although the timeline is unclear, as long as the program is successful in reducing certain undesirable measures such as 30-day patient readmissions and does not harm the patient, continual expansion throughout the two hospitals will likely commence.

Harming the Doctor-Patient Relationship

A major concern for Naples residents regarding the pilot program is the possibility that it will jeopardize the doctor-patient relationship with their established independent primary care and concierge physicians. This leads to patient and primary physician concerns about care quality as hospitalists, who may not know the patient, their medication, or their comorbidities, would control their in-patient care.

The independent physicians are also concerned about the potential elimination of their admitting privileges as the program continues, effectively squeezing them out of the market. Because of the pilot program, an increasing number of independent physicians will not be caring for patients at the hospital; therefore, hospital privileges may not be renewed as the hospital bylaws require physicians to have at least documented patient contracts.

In response to this pilot program, attorneys hired by a group of physicians and patients are demanding that the NCH board withdraw the policy, and the Collier County Commission has agreed to send a formal letter requesting an explanation for the motive behind the program's expansion. Due in part to public pressure to rescind the policy, the CEO and Chief of Staff of NCH Healthcare System resigned on January 23, 2019.

While the public backlash has certainly stymied the rollout of the Hospitalist Model, the attorneys have indicated their intent to take further legal action to protect the interests of the physicians and patients involved if the current pilot stays in place.

The Referral Rules Impact Competition

Essential to the legal case, NCH-employed physicians are required to refer to NCH-employed specialists, impacting competition to third-party specialists and potentially lowering the quality of care by restricting choice. According to the attorneys, this policy change could affect NCH's license with the state of Florida, due to a state statute being eliminated that ensures physicians can use admitting privileges based on expertise.

Additionally, the attorneys state that if the program continues, NCH could lose Joint Commission accreditation as it requires physicians to be able

to use privileges based on expertise, which would be inconsistent with awarding privileges to only NCH-employed physicians. The loss of such accreditations would exclude NCH from receiving Medicare reimbursement, as well as other insurer reimbursement such as Blue Cross.

How the NCH Measures Success

The NCH board has stated generally that they will do what is in the best interest of the community. While primary care doctors may not have admitting privileges on the pilot floors, NCH assures that throughout the program, independent primary care physicians may consult the patient, review hospital records and test results, and give recommendations to the hospitalists.

Their reasoning for continued expansion of the pilot program to additional units throughout each hospital is the successful results from the initial pilot floors, resulting in reduced Medicare penalties, through a 50% reduction in hospital-acquired conditions, a 50% reduction in 30-day readmissions and a 20% reduction in length of stay.

An internist at NCH stated that these decreases are likely due to the current lack of primary care physicians who are completing rounds at the hospital (on non-pilot floors), and because hospitalists are proximate to the admitted patients they can see them, when needed, in minutes rather than hours, and they may be able to discharge the patient sooner.

Other systems, including the UCLA Medical Center, University of Cincinnati Medical Center, and Brigham and Women's Hospital, have employed similar unit-based hospitalist models with positive results, which may indicate a trend toward increased utilization of hospitalists and this admissions model.

The combination of financial penalties, such as those issued by Medicare for not meeting certain quality metrics, and the transition from volume-based to value-based reimbursement models may also influence hospitals to adopt this model in an attempt to increase quality, and consequently lower penalties and receive maximum reimbursement.

The Model's Implications for Specialties

However, in areas where hospitals are utilizing this model, more independent physicians might leave, which could cause patients to lose their primary care physician and affect their access to and continuum of care.

Further, hospitals may experience physicians from other specialties leaving their organization due to the controversy; for example, four radiologists in the NCH Healthcare System have decided to leave the system due to the allegedly toxic environment that had been created as a result of this pilot program, which, they stated, would significantly impact the operation of the facilities.

Additionally, a potential decrease in the number of local primary care or concierge physicians may result from this model as there might be little incentive to start independently practicing in the area. These two factors, i.e., an increase in primary care physicians/specialists leaving the model and a decrease in the number of non-hospital physicians, may result in reduced competition within the area, creating a potential physician shortage.

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Additionally, some independent primary care physicians may feel an increased pressure to become employed by hospitals implementing this model to ensure that they can care for their patients, resulting in more anti-competitive behaviors. As this program relies on hospitalists, it is essential that hospitals can attract these physicians, to ensure that the model will be effective. In the NCH hospitals in Naples, approximately half of admissions are made by independent physicians, and moving forward, it is estimated that a total of 35 hospitalists would need to be hired for a complete roll out.

For complete expansion of this program in any hospital, increased recruitment would be essential; however, there is a shortage of hospitalists nationally, making recruitment highly competitive. In order to combat the demand, organizations wanting to employ this model might turn to foreign medical graduates for the hospitalist positions, as NCH is considering. For organizations unable to successfully recruit and retain a substantial number of physicians, this model will likely be unattainable.

The Model's Future

A rollout of The Hospitalist Model to the remaining floors of the NCH hospitals, as well as in other hospitals, may be precipitated by the current reimbursement landscape, in which hospitals are incentivized to meet quality metrics and thereby decrease financial penalties and increase their reimbursement yield.

But hospitals may face pushback from the community similar to that of NCH, who may believe that the hospital is trying to squeeze out competition from independent and concierge physicians. However, the ultimate utilization of this model may depend on the outcome of any legal action initiated over this pilot initiative.

Jessica Bailey-Wheaton, Esq., is vice president and general counsel; Todd A. Zigrang, MBA, MHA, is president of Health Capital Consultants, a nationally recognized healthcare economic and financial consulting firm based in St. Louis, Missouri.