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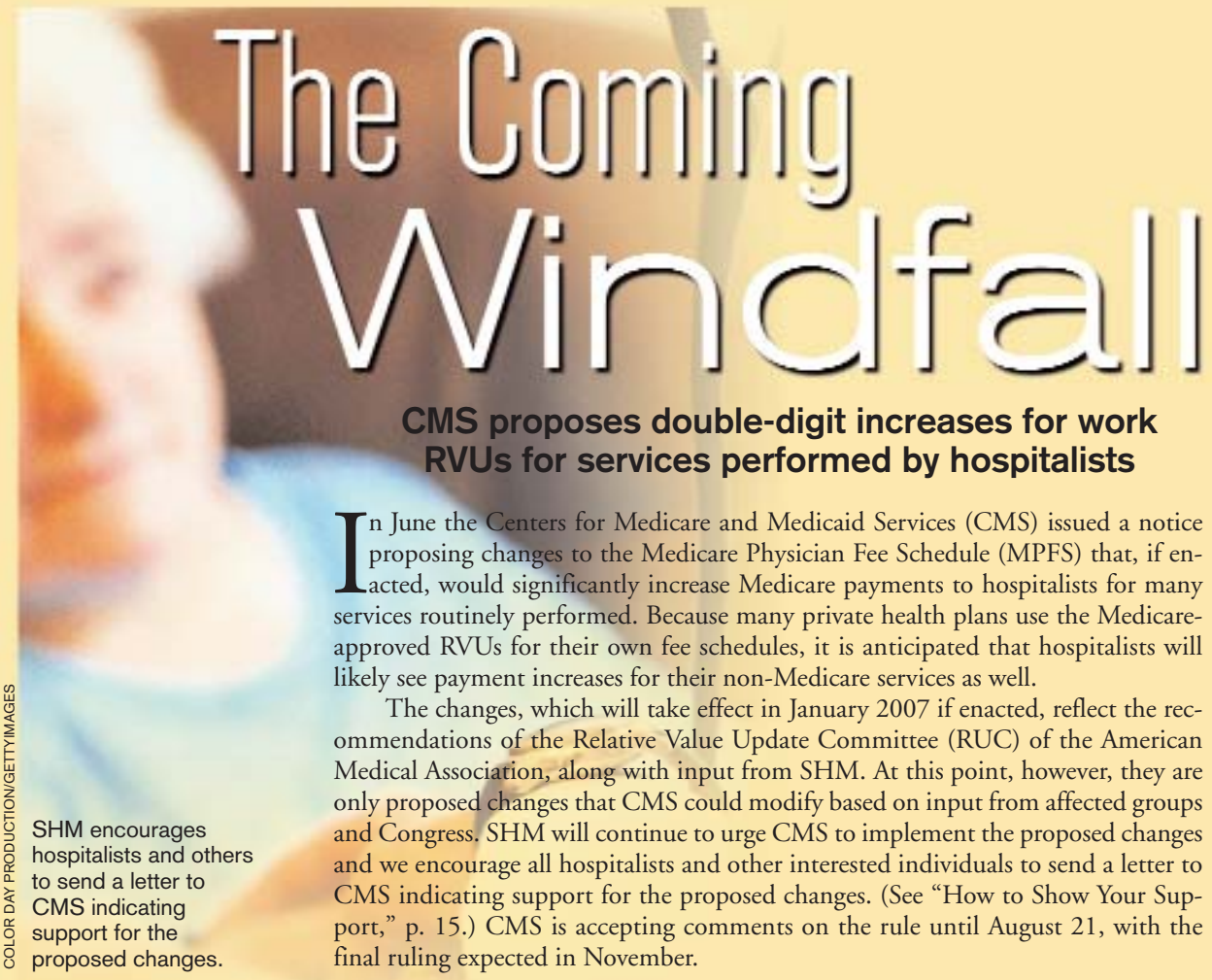

The Coming Windfall

CMS proposes double-digit increases for work RVUs for services performed by hospitalists

In June the Centers for Medicare and Medicaid Services (CMS) issued a notice proposing changes to the Medicare Physician Fee Schedule (MPFS) that, if enacted, would significantly increase Medicare payments to hospitalists for many services routinely performed. Because many private health plans use the Medicare-approved RVUs for their own fee schedules, it is anticipated that hospitalists will likely see payment increases for their non-Medicare services as well.

The changes, which will take effect in January 2007 if enacted, reflect the recommendations of the Relative Value Update Committee (RUC) of the American Medical Association, along with input from SHM. At this point, however, they are only proposed changes that CMS could modify based on input from affected groups and Congress. SHM will continue to urge CMS to implement the proposed changes and we encourage all hospitalists and other interested individuals to send a letter to CMS indicating support for the proposed changes. (See "How to Show Your Support," p. 15.) CMS is accepting comments on the rule until August 21, with the final ruling expected in November.

COLOR DAY PRODUCTION/GETTY IMAGES

SHM encourages hospitalists and others to send a letter to CMS indicating support for the proposed changes.

Tough Negotiations Avert B.C. Hospitalist Walkout

By Gretchen Henkel

Two weeks of intense talks between hospitalists and government officials resulted in an 11th-hour compromise on June 29th in British Columbia, one day before hospitalists' contracts were set to expire. Throughout the month of June, the B.C. hospitalists had threatened to move back to community practice if the Ministry of Health (MOH) did not offer a contract that recognized the value of their work. The hospitalists contended that low payment schedules and staffing levels were seriously undermining staff retention and recruiting—as well as patient safety. During the dispute, MOH officials had been equally adamant about their position. The province's Minister of Health, George Abbott, said that the salaries were fair, and that the government would not be "held for ransom on this issue."

Hospitalists believed that failure to reach agreement would have left many hospitals scrambling to provide coverage for hospitalized patients.

Wayne DeMott, MD, is a hospitalist at Royal Jubilee Hospital in Victoria, B.C., and chief negotiator for the British Columbia Medical Association's Section of Hospitalist Medicine. CONTINUED ON PAGE 11

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TOUGH NEGOTIATIONS AVERT B.C. HOSPITALIST WALKOUT

By Gretchen Henkel

COMPLETE DETAILS.

PLUS: WHAT WE CAN LEARN FROM OUR CANADIAN PEERS

Hospitalists in B.C., he says, "are in a position to … severely compromise many functions of most major hospitals in this province. If an agreement had not been reached, we were quite prepared to stand up and take our leave."

The June 29 compromise established a one-year period to re-examine workload issues and clarify funding models. If hospitalists are not satisfied at the six-month mark with the provisions to address ongoing funding, workload, recruitment and retention issues, they can give six months' notice.

ROOTS OF THE DISPUTE

The majority of primary care in British Columbia has traditionally been provided by general practitioners. According to David Wilton, MD, one of the directors of the Vancouver Hospitalist Society, a non-profit society that contracts with Vancouver General Hospital and the University of British Columbia Hospital (overseen by the Vancouver Coastal Health Authority), and a core negotiator for B.C. hospitalists at the talks, "the economic model for hospital care faltered through the late '80s and early '90s, and general practitioners started giving up their hospital privileges and focusing on their community-based practices."

To fill the gap, many hospitals in the more populated urban areas started hospitalist programs, which evolved through the late '90s and grew quickly after the year 2000. One of the largest health authorities in the province—the Fraser Health Authority—serves approximately 1.3 million people on the B.C. mainland, runs 12 hospitals, and now has 110 hospitalists working for that health authority alone. Most (85%-90%) Canadian hospitalists are trained in family practice medicine, as opposed to internal medicine.

In some ways, B.C. hospitalists have been victims of their own success. As programs grew and as house staff became aware of hospitalists' skill sets and expertise, many shifted their work burdens to the hospitalist services, says Dr. Wilton. The workload climbed exponentially, but appreciation of hospitalists' value-added services on the part of MOH officials did not keep pace with the workload. The result, explains Dr. Wilton, was a kind of disconnect between the intense nature of hospitalists' services and their compensation and staffing structures.

"In British Columbia the local hospital administrators saw the efficiencies that we were bringing to the system," explains Dr. Wilton. "They saw the improved quality of care and the fact that we were able to step in, be flexible, and help specialists in various areas and fill the gaps of care. But we hadn't yet broken through to the higher levels of the provincial Ministry of Health. They didn't fully recognize the value that we were bringing to the healthcare system and the fact that hospitalists are the cornerstone of the acute care system now."

Mike Morris, MD, president of the Section of Hospital Medicine, agrees with this characterization. A hospitalist at Nanaimo Regional General Hospital (part of the Vancouver Island Health Authority), Dr. Morris believes that most of the health authorities, which administer the region's hospitals, appreciate hospitalists' value. "They know how much we help the patient flow and problems in the emergency room," he says. Emergency department crowding has

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been a huge problem in British Columbia, due to lack of hospital beds and a dearth of long-term-care beds. "Hospitalists are able to come in and safely discharge people on a timely basis, and help the flow through the emergency department. That's one of our biggest values to the hospital. We think that the family physicians coming into the hospital are platinum doctors because they're keeping up with the rapid changes in hospital medicine. And we feel that they are being highly undervalued."

On average, hospitalists were making $111 an hour (Canadian dollars, equating to about $98 U.S. dollars at the July 12 exchange rate). According to Dr. Wilton, the hospitalists contended that their earning potential was at least equivalent to that of a lower-intensity Monday-Friday community-based general practice. At the negotiations, they valued their services at $135/hour. If the government was unwilling to value hospitalists' compensation appropriately, they warned they could easily return to a community-based practice model.

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PAYMENT NOT THE ONLY ISSUE

The province of British Columbia is divided into six health authorities, five of which have active hospitalist programs. Overarching compensation frameworks for all physicians are established through negotiations between the British Columbia Medical Association (BCMA) and the MOH. Individual health authorities then negotiate specific terms of compensation and workload expectations with physicians. There is considerable variation between health authorities (and indeed throughout each of the Canadian provinces) regarding hospitalists' workload models, such as the number of expected patient encounters per shift and compensation packages.

The BCMA had recently completed contract renewal negotiations involving the entire physician body in British Columbia and the government on April 1, resulting in a new six-year Letter of Agreement that hospitalists maintained did not address their needs.

"The way we saw [the Letter of Agreement] being interpreted," says Dr. Wilton, "was that the base rate for calculating our advances going forward was going to be between 10% and 25% less than what we were currently earning. Part of our goal was to get a wage that is consistent with the complexity and intensity of our work. I think that, in the eyes of the government, they were seeing our work and our value more in the range of the less-intense community-based general practice work. We wanted to shift that focus more towards the intensity of the acute care setting, where we think we're more comparable to emergency medicine and internal medicine specialists."

Dr. DeMott adds, "The workload model is a very important aspect of what we do. It isn't only what you are paid, it is what you are being asked to do for what you're being paid. Workload expectations have tremendous implications for the health of this career path in the future, the ability to recruit into this career path, and the ability to retain people, so that they do not become burnt out or personally destroyed."

VIEWS OF THE DISPUTE

B.C. hospitalists decided to hire their own attorney (the Vancouver firm of Tevlin Gleadle) and a press relations person to take their dispute public. Margaret MacDiarmid, MD, is president of the BCMA and has her own family practice in the Kootenays region eight hours east/southeast of Vancouver on the British Columbian mainland. "We [the BCMA] were very keen to assist, if we could, in the resolution of the conflict, and we were calling them about that," she explains. "But we felt we had to operate within the Letter of Agreement that we had just signed, which I think is reasonable. So we did not play any active role in the final resolution."

Assistant Deputy Minister for Medical Services Stephen Brown, PhD, the MOH official who oversees physician compensation, admits that the issue of the threatened walkout was "a bit of a surprise" to him because the government had just signed the Letter of Agreement with the BCMA. He became engaged with the health authorities and the hospitalists, "trying to understand how we got to where we were when we had just signed an agreement."

Although hospitalists felt the Letter of Agreement did not address their concerns, Brown did not characterize the talks with the various stakeholders as negotiations. "I acknowledged that we were trying to understand the issues they were presenting and how we could address those issues within the context of the BCMA-government negotiated agreement," he said during a telephone interview.

"Over the period of a couple weeks of dialogue, we got to a tentative agreement—which hopefully will now translate into contracts over the next week—that is within the framework of the Agreement."

GOALS ACCOMPLISHED

Key figures involved in the talks expressed satisfaction with some of the goals achieved. Dr. Wilton reflects that the dispute has resulted in more public awareness of the presence of hospitalists and more awareness of hospitalists' value within the BCMA. Most importantly, he says, "we sat across the table from some of the senior administrators in the Ministry of Health and were able to educate them about the values that hospitalists can bring to the system. We're hoping that by having the opportunity to educate them, they will take a more proactive and organized approach to supporting the hospitalist model of care and utilizing it to its full potential."

"I wasn't thrilled that we were in this situation," says Brown. "But the positive that's come out of it is that I think we've got a platform, we've got a dialogue, and we have committed to work with them over the next six months to look at workload and see if we can get some level of consistency on that."

Brown indicated that he had acquired more understanding of how hospitalists' roles have evolved in the province and the difficulties they encounter to provide quality care. "The reality of what we found was that regions had developed hospitalist services in slightly different ways, with slightly different compensation arrangements," he noted. "I hope what we have just done is we have now created the same platform for all the hospitalists across the province. They're going to have a contract that looks similar and dialogue is now underway with the HAs [health authorities] about the range of services that hospitalists will provide. So I think that's an opportunity as well, over the next six months now, to clean that up."

While hospitalists gained some traction on the development of new workload standards, they did not fully accomplish their financial goals, the two key negotiators said. According to Dr. DeMott, "We became lost in a complex political and economic struggle that involved all of the doctors in the province. The doctors had recently ratified an agreement that left us completely out in the cold. In the end, we had to comply with the essential terms of that [BCMA-negotiated Letter of Agreement]."

To have insisted on the hospitalists' financial goals, he says, would have injured too many programs, and—if they had walked off the job—ultimately would have compromised patient care. "In the end," says Dr. DeMott, "we acquiesced and came up with a compromise that should work for the short term."

PARALLELS WITH THE UNITED STATES?

Many of those interviewed for this article observed that hospitalist programs in British Columbia are still evolving, and that U.S. hospitalist programs are probably five years ahead in terms of established program models. Dr. DeMott praises the pioneering work done by SHM: "We look to you for guidance, and we really do appreciate the SHM advancement that is moving the hospitalist profession along."

As negotiators for the Section of Hospital Medicine during the talks, Dr. DeMott says that his team used the surveys and studies that SHM has pioneered about the value-added contributions of hospitalists to increase awareness with the MOH, the government of British Columbia, and the BCMA about hospitalists' roles. Dr. Morris notes that B.C. hospitalists, taking the lead from SHM, are now developing their core competencies.

William D. Atchley, Jr., MD, FACP, medical director of Peninsula Inpatient Care Specialists at Sentara Careplex Hospital in Hampton, Va., is a long-time member of the SHM board of directors. He has followed the growth of hospitalists in Canada, and applauds the efforts of those like Echo-Marie Enns, MD, who served as a National Association of Inpatient Physicians (NAIP) Canadian chapter president in Calgary. He has also conducted surveys of Canadian hospitalists. He doubts that a parallel strike situation could develop here in the United States.

"Their situation is unique to Canada," he says. "From SHM's perspective, we have always acted as an advocate for hospitalists in Canada and offered whatever we have learned here in the United States to help facilitate their movement. They are still in the process of explaining what a hospitalist is, and explaining to their national medical societies about what hospitalists can do. Their ability to get the message across is just going to take some time."

Summing up their accomplishments thus far, Dr. DeMott says, "We considered this disagreement a defining moment for hospitalists in this province and quite possibly for [Canada]. We're not there yet, but we put ourselves on the map. There will likely be another battle on the horizon for us, but hopefully one colored by a much greater appreciation of the expertise we bring to the acute care arena." **TH**

Gretchen Henkel writes regularly for The Hospitalist.