

## Chapter 8: The Relationship of Hospitals and Physicians

### *Key Points*

- **Hospitals and physicians do not operate on a common or compatible set of practice-oriented and financial concerns with respect to the medical management of patients and the provision of in-patient services. Provider payment models for acute hospital care should be developed and piloted that better align incentives for physicians and hospitals.**
- **Ambulatory care facilities have created new economic challenges for hospitals. These centers, generally owned in part by physicians, do not have the same regulatory requirements as hospitals. Regulations should be evenly applied across all facilities with respect to reporting of cost and quality data.**
- **Physicians face little accountability for consumption of hospital resources. Validated performance measures are needed to begin a program of public reporting to increase quality and cost-effectiveness of care.**
- **Hospital costs are generally unknown to providers and patients. Increased transparency of hospital acute care costs and utilization data is needed to enable more cost-effective care.**
- **There are many opportunities to improve efficiency and quality of inpatient hospital care. Hospitals should seek to expand more services to extended hours, explore the use of practice extenders, and implement alternative physician staffing models to facilitate more efficient, high quality care.**
- **There are no financial incentives to coordinate care or insure patients have access to continued care once they leave the hospital. Guidelines and financial incentives need to be developed and implemented to improve care coordination across the full continuum of care.**

The complex nature of hospital-physician relations in the US health care system has profound consequences on the economics and management of hospitals. Although growing in popularity, physicians generally are not salaried employees of hospitals. Rather, independent physicians have “privileges” at a given hospital that entitles them to provide medical services within the respective facility. In exchange for these privileges, physicians are often expected to provide certain service on behalf of the hospital (e.g. hospital committees, on-call ER availability). In turn, hospitals are dependent on these physicians as a referral base for patient volume. This arrangement in the US health care

system is a long-standing tradition that has only recently shown signs of changing with the rise of hospitalist physicians. It is a peculiar economic relationship because physicians benefit financially from the use of hospitals but do not bear direct responsibility for the fiscal health of these institutions.

The Commission examined factors related to the relationships of physicians and acute care hospitals that affect the performance of hospitals including issues such as differences in financial incentives for clinical services for physicians and hospitals, the availability of physician services in hospitals, competition from free-standing

facilities, transparency of cost and quality data, and the general coordination of care across the clinical continuum. There was a range of issues that arose in the Commission's discussion that affect the interaction of hospitals and physicians that were beyond the scope of its work including but not limited to regionalization of health care resources, medical liability reform, and alternative strategies for the delivery of acute care services.

The Commission has adopted a number of recommendations aimed at improving elements of the relationship among New Jersey's acute care hospitals and their physicians to improve the financial condition of essential hospitals. While many of these recommendations will require the agreement and collaboration of different stakeholders and may take considerable time and energy to implement, the governors, trustees and senior management of each acute care institution bear direct and ultimate responsibility for the fortunes of facilities under their collective direction and control.

## **I. Misalignment of Hospital and Physician Financial Incentives**

Physicians and hospitals do not share the same financial incentives and concerns when patients are hospitalized for inpatient services. Hospitals generally face strong utilization controls in the form of prospective payment (i.e. DRGs – bundled payment determined by diagnosis and severity) or utilization review tied to per diem payments (negotiated daily rate which can be downgraded if deemed unnecessary). Physicians on the other hand face an entirely different set of financial incentives for inpatient services for the same hospital stay. Physicians are generally paid on a fee for service basis for inpatient services and face fewer utilization controls. Although a payer could decide to downgrade a hospitalization as medically unnecessary, a physician can continue to be paid for daily services while the hospital is likely to be paid far below cost.

Admission and discharge decisions are generally made by physicians and not under the immediate control of the hospital. In addition, physicians have the primary role in determining what resources are utilized within the hospital through the ordering of diagnostic tests, consulting other physicians, or moving patients to

different levels of care (i.e. ICU). Yet the hospital is financially liable for many of these decisions and currently has few tools at its disposal to address over-utilization of resources by physicians. The Commission heard a presentation from a consultant where costs for similar risk patients with a similar diagnosis varied by a magnitude of five depending on the physician caring for the patient within a given hospital. The fact that physicians are generally not employees of the hospital and the hospital itself is dependent on these very physicians for referrals makes it difficult for a hospital to exercise effective managerial control over these issues.

Misaligned incentives are not limited simply to excess utilization driven by physician clinical decision-making in the absence of financial liability. New Jersey physicians receive some of the lowest reimbursement rates in the nation for treating Medicaid patients, while hospitals are paid at considerably higher rates. Such a misalignment of incentives is regarded as a key reason for lack of physician availability in hospitals serving a large proportion of Medicaid patients.

Closer alignment of hospital and physician financial incentives for hospital care holds significant potential for improving the cost effectiveness and rationality of health care resource utilization. There are several strategies that may be employed to help achieve such a goal including goal-based incentives, reimbursement systems for physicians based on severity-adjusted Diagnosis-Related Groups (DRGs) or Relative Value Units (RVUs), or other means of sharing gains in productivity and cost-savings. Detailed study and evaluation of plans and strategies for improving alignment of payers<sup>72</sup>, hospital and physician financial incentives would be a key step to remedying poorly aligned incentives.

Better alignment of financial and practice incentives among hospital systems, physicians and payers will help close service gaps, promote common goals, and encourage more cost-effective practices. The absence of a coherent framework of incentives for providing and compensating cost-effective medicine and care is at the root of the problem. However, any such initiative must

<sup>72</sup> "Payers" as used here refers to public and private third party payers, and excludes self-insured individuals or co-payers.

take measures to avoid the risk that, as physicians and hospitals payments are more closely aligned, patients' interests are not unduly constrained. For example, patients who, for medical reasons, should receive extended or more intensive care may be faced with increased or more complex barriers. Safeguards including procedural checks, rights to second opinions, and a swift and straightforward route of review and appeal are essential to assure fairness and protection of patient rights as the economic interests of physicians, hospitals and payers are brought into alignment.

Alignment-oriented payment schemes that provide physicians appropriate incentives for cost-efficient case management through case-rates or severity-adjusted payments but that do not unduly impose penalties for unavoidable or unintended consequences should be thoroughly examined. This is an area requiring careful study of alternatives and demonstration projects before widespread implementation can confidently be recommended. The following considerations are important components of future efforts to better align incentives among physicians and hospitals for cost-effective care:

- Educate and incent physicians to practice cost-effective medicine, reward physicians based on system cost savings, and eliminate or reduce incentives to over utilize resources and continue defensive medicine tactics.
- Rationalize the appropriate use of consultants and consulting practices through physician and medical student education.
- Align financial incentives and liability exposure for hospitals and physicians to improve physician accountability for appropriate use of hospital resources.
- Establish uniform hospital and physician payment criteria for all payers (public and private sector.)
- Avoid payment systems that improperly incent hospitals, physicians or payers to withhold, curtail, or deny medically necessary care.

<sup>73</sup> Ambulatory surgery facilities, as defined by NJAC 8:43A-1.3, are commonly referred to as ambulatory surgery centers (ASCs). The term ASC is used to refer to such facilities throughout the report.

<sup>74</sup> NJAC 8:43A-1.3 "Ambulatory care facility" means a health care facility or a distinct part of a health care facility in which preventive, diagnostic, and treatment services are provided to persons who come to the facility to receive services and depart from the facility on the same day. Ambulatory surgery centers are a type of ambulatory care facility.

**Recommendation:**

The State should encourage or support the development of new provider payment models for acute hospital care that better align financial incentives for physicians and hospitals.

1. Funding for new incentives required to implement such a system must come from savings generated within the present scope of payments and reimbursements.
2. Safeguards must be built-in to protect patient rights for all medically necessary care and provide percentage-based payment for out of network services.
3. Payer fee schedules should be transparent through complete and public disclosure.
4. A carefully designed, geographically limited and closely monitored pilot or demonstration project would be a prudent first step.

**II. Proliferation of Ambulatory Care Facilities**

In recent years, the nation has witnessed high growth rates in the number of free-standing ambulatory care facilities such as ambulatory surgery centers (ASCs).<sup>73,74</sup> These centers, often owned in part by physicians, provide services that do not require overnight stays in the hospital. Among ASCs, ophthalmology and gastroenterology surgical procedures are the most common procedures.<sup>75</sup> In recent years, hospitals have expressed concerns that freestanding ambulatory care facilities, particularly surgery facilities, are eroding hospital's fiscal health by attracting highly profitable services away from hospital outpatient departments. Research corroborates hospitals' concerns – one study of surgical procedures found that for each additional ASC per 100,000 people, hospital outpatient surgical volume decreases by 4.3 percent.<sup>76</sup> A study of Horizon Blue

<sup>75</sup> Among Medicare beneficiaries nationwide, ophthalmology and gastroenterology surgical procedures account for more than two-thirds of all ASC services provided. [Source: MedPAC; available online: [http://www.medpac.gov/publications/congressional\\_reports/Jun04DataBookSec8.pdf](http://www.medpac.gov/publications/congressional_reports/Jun04DataBookSec8.pdf)]

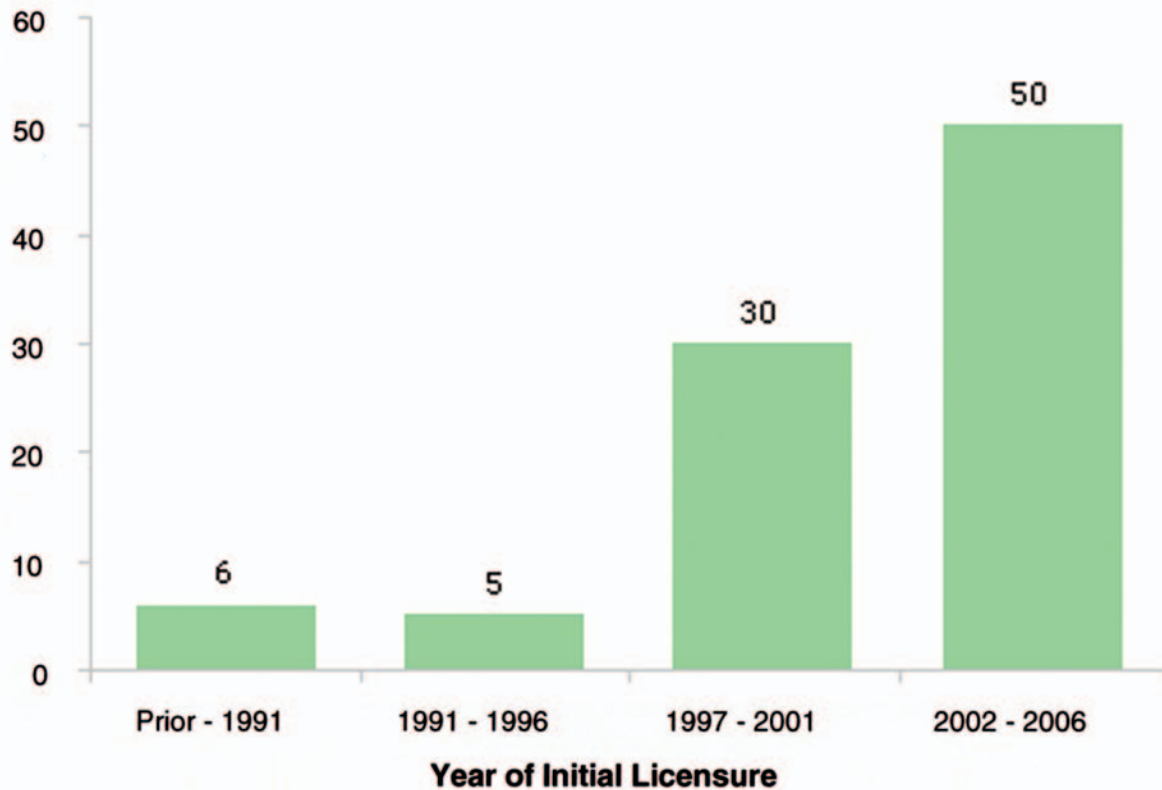
<sup>76</sup> Bian, J., & Morrissey, M.A. Free-standing ambulatory surgery centers and hospital surgery volume. *Inquiry – Excellus Health Plan*. 2007; 44(2): 200-10.

Cross Blue Shield claims between 2003 and 2005 found that claims paid for ASCs increased by 22.5% compared to just 0.8% for hospitals.<sup>77</sup> The Commission’s analysis of New Jersey hospitals indeed found that surgical volume is an important positive predictor of profitability. The erosion of surgical volume poses a financial threat to acute care hospitals as cross subsidies from profitable to less profitable health services declines.

Hospitals are further challenged by their regulatory mandate to provide certain care to all patients regardless of ability to pay while freestanding ambulatory care facilities do not face any such requirement. As a result, these facilities are likely to disproportionately attract paying patients in comparison to hospitals whom are likely to be left with residual charity cases.

In New Jersey, the number of ambulatory surgery centers has grown at an extremely rapid pace, 34% in just a four-year span from 2001 to 2005 (see Figure 8.1).<sup>78</sup> This mirrors national trends where physicians are increasingly providing more services outside of hospital facilities.<sup>79</sup> Financial incentives for physicians strongly encourage this trend. Income from services in free-standing ambulatory care facilities is shielded from subsidizing unprofitable services and is free of charity care obligations unless the physician elects to provide such care. Even those physicians that do elect to provide charity care are able to control the volume in ways hospitals are currently unable. An ambulatory assessment on free-standing facilities in part offsets this competitive advantage and provides some support for Charity Care costs.

**Figure 8.1:**  
**Number of Operating State-Licensed ASCs by Year of Initial License (2006)**



Source: Avalere Health LLC. 2006 New Jersey Health Care Almanac.

<sup>77</sup> Avalere Health LLC. 2006 New Jersey Health Care Almanac. Available at: [http://www.avalerehealth.net/research/docs/New\\_Jersey\\_Almanac/New\\_Jersey\\_Almanac\\_Summary.pdf](http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf).

<sup>78</sup> Avalere Health LLC. 2006 New Jersey Health Care Almanac. Available at: [http://www.avalerehealth.net/research/docs/New\\_Jersey\\_Almanac/New\\_Jersey\\_Almanac\\_Summary.pdf](http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf).

<sup>79</sup> Pham, H.H. & Ginsburg, P.B. Unhealthy trends: the future of physician services. *Health Affairs*. 2007; 26(6): 1586-98.

The proliferation of freestanding ambulatory care facilities as a major competitor to hospitals highlights the complex relationship between physicians and hospitals. In the same day, a physician can perform procedures on patients in their own facility and then walk down the street to the hospital they are competing with to provide more complex care to sicker patients. This is a striking peculiarity to the physician-hospital relationship where two parties can simultaneously be competitors and partners.

Ambulatory care facilities argue that they are providing high quality care in a more cost effective environment than in hospital outpatient departments. These claims, in part, are based on the notion that physician ownership increases physician investment in efforts to improve quality, safety, and efficiency. While these claims may in fact be true, they are nearly impossible to verify in the current health care environment. Freestanding facilities are not required to report the same quality, safety, or financial data required as hospitals must to the State. No private entity exists that serves such a function either. Centers can pursue voluntary accreditation through private organizations; however, this process and data reporting is not transparent to policymakers or the public. This lack of transparency does not serve patients well as they are asked to “shop around” for health care services nor does it serve the State well in terms of monitoring the performance and quality of health services.

Ambulatory surgery centers are an example where current regulations are not evenly applied across facilities. In 2006, there were 181 Medicare-certified ASCs in New Jersey. However, there are just 95 state-licensed facilities.<sup>80</sup> The difference is most likely explained by the licensure exemption for physician-owned surgical practices with a single operating room that are not currently subject to licensure requirements by the Department of Health and Senior Services (DHSS).<sup>81</sup> This situation arises because the Board of Medical Examiners currently has oversight over

physician practices while the DHSS regulates facilities. In the Commission’s view, these uneven licensing standards are largely without basis and should be evenly applied across all facilities providing similar services.

### A. Policy Solutions

While freestanding ambulatory care facilities are undoubtedly affecting the finances of hospitals, it is less clear what the appropriate policy solution is given the current state of affairs and the already widespread proliferation of such centers. The Commission recognizes that it is neither possible to “roll back the clock” and move to a time without these facilities nor is it clear that it would in fact be desirable. Free-standing ambulatory care facilities may be providing a more convenient and cost-effective service that is reflective of long-term trends of moving more care out of the hospital and with shorter stays. However, the lack of uniform regulations and reporting of quality and performance data is a major impediment to understanding their actual impact on the health care system or the quality of care. Any rational policymaking needs to include more robust data reporting requirements on the part of these facilities with respect to quality and cost and apply uniform regulations based on the services provided rather than the specific venue as is the case with the current exemption for single operating room surgical practices.

Freestanding ambulatory facilities have also argued that they should not bear the burden of solving hospitals’ financial problems. The Commission agrees that the fiscal distress of hospitals arising from the emergence of these facilities is merely a symptom of a dysfunctional payment system that under-reimburses medical services relative to surgical and diagnostic services and publicly insured patients relative to the privately insured. If payments were more equitable across payers and services, many of these problems would disappear. Free-standing ambulatory care centers are not entirely to blame for the fiscal problems of hospitals and it is less clear what role they ought to play in remedying the situation.

Some have argued that freezing the numbers of centers at current levels would address the fiscal challenges facing hospitals. Such a policy change would grant current centers monopolistic market power by hindering the entry of competitors in local areas. Such a move

<sup>80</sup> Avalere Health LLC. 2006 New Jersey Health Care Almanac. Available at: [http://www.avalerehealth.net/research/docs/New\\_Jersey\\_Almanac/New\\_Jersey\\_Almanac\\_Summary.pdf](http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf).

<sup>81</sup> Subject to oversight by the Board of Medical Examiners

would need to be joined with payment regulation to address these monopolistic tendencies. Others have called for these centers to have similar requirements as hospitals to provide charity care. While this may be an attractive option to create a more level playing field in the marketplace, it is less clear how such a provision could be enforced or monitored. In addition, the referral mechanisms for freestanding ambulatory facilities would likely shield many of these centers from a large charity care burden regardless of regulatory requirements. Finally, some have raised questions about whether the “Codey” law<sup>82</sup>, a law that limits the ability of physicians to refer patients to facilities in which they have an ownership interest, should be applied to ambulatory care facilities. This question has not been clearly resolved – the Board of Medical Examiners has interpreted the law to allow for such referrals while a recent Superior Court decision articulated a narrower interpretation. Resolution of this conflict is necessary to determine what impact this law may have on the economics of hospitals.

#### **Recommendations:**

- The State should eliminate the licensure exemption for single operating room surgical practices. The Department of Health and Senior Service should assume responsibility for licensure. All surgical facilities in New Jersey should meet nationally recognized accreditation standards.
- The State should require all ambulatory care facilities to report cost and quality data similar to requirements currently imposed on hospitals. Regulatory and reporting requirements should be evenly applied across facilities.
- The State should require public posting of list prices (charge masters) and prices charged uninsured patients by all ambulatory care facilities.
- The Board of Medical Examiners should require that physicians and other licensees of the Board provide written notice to patients of any significant financial interest held by that physician or his or her practice in a health care entity to which the practitioner refers patients.

<sup>82</sup> N.J.S.A. 45:9-22.4 et seq.

### **III. Lack of Data on Quality of Care**

Data is a key ingredient of any effort to increase accountability, engage in quality improvement, or provide feedback to providers. Like other states, New Jersey’s health care system does a relatively poor job of collecting and reporting data in a systematic manner. As a result, providers do not receive data on the quality of care they provide nor do they receive feedback on the costs of clinical services. Without this knowledge, expecting providers to be accountable and responsive to variances in quality or cost is simply an illusion.

Establishing standards and measures of quality and efficiency for physicians and hospitals is a key to strengthening the acute care system. Measurement holds great potential to improve performance among hospital staff, physicians, and institutions. Tracking resource utilization, length-of-stay, end-of-life issues, and performance on key clinical indicators associated with the most frequent diagnoses, among other metrics, will be a key to raising quality, efficiency and performance.

The Institute of Medicine as well as other respected health policy leaders, recognizing the unacceptable variances in clinical practice and poor adherence to many evidence-based standards, has called on policymakers and health system leaders to engage in far reaching quality improvement efforts.<sup>83</sup> In response, quality standards have emerged across the country. However, even where such standards are widely recognized, New Jersey hospitals and physicians have made little progress in agreeing how to implement them, measure results, or how to reward, induce or coerce compliance. This has made it nearly impossible to assess clinical practice, identify leaders and outliers, or implement any system of evidence-based rewards and corrective action within a given institution.

Lack of confidence in and acceptance of performance criteria has been a major hurdle to widespread adoption of a common set of quality measures across New Jersey or the health care system nationally. Logistical barriers, including a lack of information technology (IT) systems

<sup>83</sup> Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academies Press, 2001.

and its associated costs has also been a significant obstacle to progress. No single institution can bear this cost in the absence of a coordinated regional or statewide effort. The source of funds to defray expenses and provide the necessary resources requires serious and careful consideration. Unless these issues can be resolved, they will mean defeat for any effort to establish quantitative standards. Discussion and more specific recommendations related to the development of clinical performance measures and a health IT system in New Jersey can be found in Chapters 15 and 16.

The implementation of professionally endorsed, evidence based, and unbiased institutional and physician metrics and reporting would be a major step forward in realizing the benefits of evidence-based medicine on a broad scale in New Jersey. Active engagement of all key stakeholders in the endeavor is essential. Though hospitals have a vital interest in physicians practicing the most cost-effective medicine, their current ability to induce such behaviors is limited. Collection and dissemination of information on physician performance, whether available to the public at large or a more limited peer group, can promote physician accountability and adherence to evidence based practice guidelines.

Many physicians regard such measures with suspicion as unwarranted intrusions into their professional prerogatives. Some find the mere suggestion of standards and the threat of publicity offensive, if not threatening, and move business to less aggressively managed hospitals. Unless the effort is based regionally or statewide, attempts to use metrics and peer-pressure will put all but the strongest institutions at a competitive disadvantage.

Physician report cards can work only if they are designed so that the information is valued and used by the physicians themselves. Standards of measurement must be widely accepted and validated if ratings and rankings have the desired effect of positively motivating and modifying behavior. Implementation of such tools demands a cooperative and collaborative effort, as well as agreement on shared goals and outcomes.

Many insurers have access to demographic and clinical data that can be used to produce performance metrics at the physician and patient level. New Jersey insurers should be strongly urged to cooperate in developing standardized quality performance reports for New Jersey similar to those developed in New York (MetroPlus) and Minnesota (HealthPartners). Such reports could represent an important component of an acute care report card initiative.

The following are important considerations for future efforts to improve measurement and reporting of clinical performance to increase quality, cost-effectiveness, and accountability:

- Broad participation in standards development encourages buy-in and reduces bias concerns.
- Regional implementation of physician report cards levels the playing field for weak and strong institutions and encourages best practices, especially in key specialties.
- Implementation may disadvantage institutions dependent on marginal providers and possibly divert business elsewhere.

### **Recommendation:**

The State's health care system must in the long-run move toward a transparent system of measuring provider quality of care. While technically difficult, efforts should be undertaken to work toward developing a properly validated, well-accepted, independently compiled, and publicly available physician report card system that measures performance and outcomes on critical, evidence-based standards of acute care practice.

1. Priority and focus should be first placed on key specialties and high-cost, high-risk conditions and diagnoses.
2. Insurers, physicians, hospitals and their respective organizations should participate in the study, research and validation required for this effort.

## IV. Transparency & Accountability for Acute Care Resource Utilization Costs

Imperfect or non-existent knowledge of the cost of care and resources inhibits physicians and consumers from making informed choices, decreases trust, and diminishes accountability for decisions. The cost of hospitalization and associated resource utilization is not widely appreciated by treating physicians, much less by the public at large. Without such information, physicians and patients may make unwarranted or inappropriate demands for non-essential services, over-use or misuse hospital resources, and fail to appreciate justified denials or consider alternatives to such services. These factors tend to raise the overall level of dissatisfaction in and distrust of many aspects of the health care system. Greater financial transparency would increase comprehension of the financial impact of treatment decisions and make creation and adoption of quality and cost performance expectations for physicians rational and equitable.

Financial transparency will:

- Engage physicians in resource utilization decisions
- Remove elements of uncertainty contributing to suspicion and distrust
- Empower consumer-directed health care choices

It is worth noting that financial transparency may threaten marginal institutions dependent on higher cost services to offset uncompensated care.

### **Recommendation:**

As part of its work, the Commission had a presentation on software capable of tracking the order entries of every physician for every medical case by type of service or supply ordered in a hospital. The Commission recommends that the State, in cooperation with leaders of the hospital industry and the medical profession, explore the availability of such software from sundry sources and its adaptability to New Jersey hospitals, with the aim of enabling every hospital to track, for every physician affiliated with the hospital, the average cost per well identified inpatient case by severity-adjusted DRG (it being understood that exceptions must be made for so-called non-standard “outlier” cases.) If such an information infrastructure is

feasible, all New Jersey hospitals should be required to use it, and financial assistance of hospitals by the State should be made contingent on the submission of such information to the State.

## V. Institutional Infrastructure and Support Systems

Hospital infrastructures and support systems are in many cases ill adapted to present institutional needs, financial realities and physician practices. Attempts by physicians and hospital staffs to compensate for these deficiencies can result in practices and behaviors that can weaken the institution and diminish the quality of care.

Unlike some hospital resources, sickness, disease and trauma do not diminish on weekends and holidays. Service and coverage reductions on weekends and off-hours impact more than patient care and convenience. They can result in needlessly extending hospital stays, may place patients at greater risk for hospital-related complications, and cause waste and delay. New Jersey’s acute care institutions should consider the economic feasibility of providing a more comprehensive range of services every day of the week to ensure timely and effective care, optimize resource utilization, and control costs.

Optimizing hospital resource utilization throughout the year is not formulaic and will require study, tailored recommendations and well-managed implementation for each institution’s unique situation. The importance and role of institutional governance in such an endeavor cannot be too strongly emphasized.

While it may not be possible for a hospital to provide every service at all hours throughout the day, there are identifiable aspects of effective coverage that all hospitals can and should maintain every day throughout the year. These include the implementation of specially trained coverage for ICU units, use of physician extenders and other actions to address deficits in on-call coverage. Enhanced availability of services has the potential to improve patient outcomes, spread workload to normally less productive hours, and reduce unjustified (and unreimbursed) length-of-stay.



### Recommendation

Hospitals' management should be encouraged to define and adopt standards of operation for an expanded range of services that optimize utilization of physical plant and human resources on a 365-day basis.

1. Where essential in-house resources or specialized services are unavailable or not cost-justified, management should seek to form and/or participate in regional networks to address the identified deficiencies.
2. Hospitals should invest in and incent programs such as Intensivist and physician extender programs that are proven to have a measurable impact on cost-savings, resource optimization, efficiency and effective patient care.
3. Funding of such programs must be internally cost-justified. The State should provide assistance in developing economic and business modeling for financially distressed hospitals.

## VI. Availability of Emergency Department Specialty Physician Services

Physician availability, particularly among certain specialties and especially in the Emergency Department (ED), is a major limiting factor in improving the overall performance of ED services and optimizing the use of physical and human resources on a daily basis. Many New Jersey hospitals report difficulties in securing on-call availability of specialist physicians. What is happening in New Jersey is part of a national trend where physicians are less inclined to accept traditional on-call obligations as physicians become less dependent on hospital admitting privileges as services shift to non-hospital settings, payments for emergency care decrease, and medical liability concerns increase.<sup>84,85</sup>

Federal law mandates that certain types of care be provided by hospitals – emergency care, obstetrical services for women in labor, and care for psychiatric emergencies.<sup>86</sup> As a result, hospitals are required to maintain access to on-call specialists in their emergency rooms. Many hospitals can no longer enforce ED service call obligations on physicians, and in a growing trend, must pay significant fees to physicians in order to

secure urgently needed and essential coverage. While this may not be a burden to some institutions, it is undoubtedly problematic for others. In some cases, the lack of ED on-call physicians means patients have limited access to needed medical care and lack of appropriate follow-up or continuity. Change is needed to ensure all acute care institutions have the access to critical specialty physicians needed to fulfill their obligations.

Historically, ED service obligations were more or less expected from physicians in consideration for attending privileges. A return to the former “soft” system of obligation is not anticipated. One option is a mandatory on-call requirement for all physicians. However, making on-call service “mandatory” for all physicians via regulation, legislation or hospital policy raises difficult questions of equity, bargaining power, legality and enforcement.

Fines and licensure actions seem too extreme, while suspension or curtailment of privileges is not a realistic option for many institutions. Moreover, the institutional landscape is not uniform. Requiring obligatory on-call service would be far less burdensome on physicians in suburban hospitals due to the relatively small number of charity care and Medicaid cases. Urban hospitals, in contrast, would face difficulty recruiting and retaining physicians who could expect to shoulder a substantial burden of uncompensated care. (There is also a widespread but largely anecdotal perception that charity care patients pose a higher medical liability risk than other patients.)

Paying for on-call services is a poor solution but in some cases a necessary strategy, inasmuch as hospitals are mandated to provide certain services under the

<sup>84</sup> O'Malley, A.S., Draper, D.A., Felland, L.E. Hospital emergency on-call coverage: Is there a doctor in the house? Center for Studying Health System Change. Issue Brief No. 115. November 2007. Washington D.C.

<sup>85</sup> On-call physicians are (unlike hospitals and their employees) fully exposed to tort liability and risk not being compensated for treating the uninsured (unless, as is increasingly the case, the hospital has contracted them to do so).

<sup>86</sup> Emergency Medical Treatment and Active Labor Act (EMTALA) – the Act mandates that patients presenting to a hospital emergency rooms have the right to an evaluation and to be stabilized if they have a medical or psychiatric emergency or receive obstetrical services if they are a woman in labor.

Emergency Medical Treatment and Active Labor Act (EMTALA). Where such arrangements provide for flat fees only and do not pay for each episode of care, there is a built-in bias toward under-delivery and over-payment. Moreover, flat fees are paid independent of any reimbursement or other compensation a physician might receive. A better system might tie payments to services actually rendered on some equitable pre determined basis.

Establishment of and participation in a comprehensive system of regionalized care or Centers of Excellence and expedited transfers may provide a medically responsible and financially sustainable means meeting public expectations of the ED service, as well as the legal demands of Charity Care and EMTALA mandates. The widespread use of such centers has the potential to change the current paradigm of ED care and alter the traditional pattern of reliance on on-call services.

The crisis in on-call service is exacerbated by the problems and risks, real or perceived, of providing care in the ED setting. The issues of compensation and liability for providing such services need to be addressed to ensure adequate and consistent on-call coverage and continuity of care.

### **Recommendation**

Physician obligations and expectations with respect to ED service should be standardized to ensure adequate medical coverage and fulfillment of statutory mandates. These obligations should be part of hospital and physician licensure requirements through action by the Department of Health and Senior Services and the State Board of Medical Examiners.

Other actions that could be examined to increase physician on-call availability include:

1. Increased incentives for Medicaid and uninsured cases, compensation for taking calls in urban areas, and perhaps malpractice premium relief.
2. Compensation for EMTALA-related services on an episode-of-care basis rather on a flat fee basis.
3. Regional Coordination and Centers of Excellence should be examined in light of their impact on demand for on-call services.
4. Lifetime or age cap for on-call service hours.

## **VII. Cost Effective Staffing Models for Acute Care Services**

Changes in staffing models hold potential for decreasing costs or increasing the efficiency of acute care hospitals in New Jersey. The following section explores two such models.

### **A. Intensivist Model for Intensive Care Units (ICUs)**

Intensive Care Units (ICUs) provide patients with life-sustaining medical and nursing care on a 24-hour basis but are not typically staffed with specially trained personnel. Typically, ICU patients are among the sickest, highest risk and most expensive cases in the hospital. Using trained staff whose only responsibility is the care of patients in the unit can maximize quality of care and cost-effectiveness in the ICU. Such “intensivist” programs, when properly executed are recognized as cost-saving measures that improve the quality of patient care.<sup>87</sup> The Leapfrog Group estimates that more than 50,000 lives could be saved each year in US hospitals through universal implementation of intensivist programs.<sup>88</sup> They estimate that a hospital with 6 to 18 bed ICU could save from \$510,000 to \$3.3 million per year.<sup>89</sup>

A minimum requirement for such a program would provide service on a 365-day basis for at least eight hours per day, preferably during hours of greatest risk and/or limited coverage. In some institutions, telemedicine and remote centers can be a highly effective and cost-efficient means to implement intensivist capabilities in whole or in part.

<sup>87</sup> Pronovost et al. Physician staffing patterns and clinical outcomes in critically ill patients: a systematic review. *JAMA*. 2002; 288: 2151-62.

<sup>88</sup> The Leapfrog Group. ICU Physician Staffing – Fact Sheet. [http://www.leapfroggroup.org/media/file/Leapfrog-ICU\\_Physician\\_Staffing\\_Fact\\_Sheet.pdf](http://www.leapfroggroup.org/media/file/Leapfrog-ICU_Physician_Staffing_Fact_Sheet.pdf)

<sup>89</sup> Conrad, DA & Gardner M. Updated Economic Implications of the Leapfrog Group Patient Safety Standards. Final Report to the Leapfrog Group. 2005. Published at [http://www.leapfroggroup.org/media/file/Conrad\\_Updated\\_Economic\\_Implications\\_2\\_.pdf](http://www.leapfroggroup.org/media/file/Conrad_Updated_Economic_Implications_2_.pdf)

**Recommendation**

Adoption or implementation of an Intensivist Model of ICU Care should be a priority for acute care hospitals statewide and especially financially distressed institutions.

1. Hospitals should be encouraged, rewarded and/or recognized for implementing intensivist programs and capabilities.
2. The State or other organizations should enable and assist program development wherever possible.

**B. Practice Extenders**

Physician availability is a critical factor that impacts a hospital’s ability to respond effectively to patient need and efficiently utilize its resources. Reduced services, staffs and coverage on weekend and holidays, declines in on-call physician availability and shortages of key medical specialties can limit access and availability.

Even where physicians are available to provide in-patient coverage, the pressure to maximize the use of their professional hours is often extreme, reducing the amount of time available to each case and each situation demanding their attention. These factors contribute to service bottlenecks and inefficiencies, and may result in added costs and increased risk.

While there is no short-term means for increasing the supply of specialty physicians in under-served localities in New Jersey, there are other strategies for leveraging scarce physician resources in the acute care setting that potentially offer economic and quality improvements. In many situations, “practice extenders”, such as intensivists, case managers, hospitalists, physician assistants and advance practice nurses have the potential to provide cost-effective means of achieving quality and efficiency goals in appropriate circumstances. Advanced practice nurses, for example, have independent practitioner (IP) status which enables them to be independently compensated. Recognition of and compensation for the services of other practice extenders, such as Physicians' Assistants (“PAs”), would expand their use, helping to realize more effective and cost-efficient resource utilization.

According a class of practice extenders such as Physicians' Assistants IP status might facilitate this, and

could allow greater flexibility in matters such as getting orders co-signed within narrow time constraints. On the other hand, this may raise new issues of practice autonomy, training and expertise, and liability. It is also not clear whether and under what circumstances Physicians' Assistants themselves might desire or accept independent status. Any such change will require further study and should not distract attention from the need to expand their utilization through recognition of and compensation for the value added.

Other capabilities such as telemedicine services could, if appropriately compensated, help multiply the effective reach of vital physician services. Financial incentives or support from the State or other organizations may be required to overcome cost barriers to acquiring the IT infrastructure needed for telemedicine and remote monitoring.

**Recommendation**

Hospital management should explore and expand the use of practice extenders and other options for leveraging, extending and augmenting the professional presence and expertise of physicians.

1. Payers should provide enhanced compensation for the use of selected practice extenders, such as Physician Assistants and Advanced Practice Nurses, even if not separately compensated as “Independent Practitioners” in both cases.
2. Hospitals should work closely and cooperatively with its physicians and regional hospitals to optimize the benefit of such efforts for patients, doctors and the institution itself.
3. The State should assist financially-distressed institutions in identifying qualified consultants and solution providers who can help define and implement such initiatives.

**VIII. Coordination of the Continuum of Care**

New Jersey’s health care system does not adequately ensure the management of a patient from admission through in-patient treatment to discharge and outpatient follow-up. Lack of organizational structures and financial incentives for such a continuum of care adversely affects medical outcomes and increases the total cost of medical care. Discontinued care or lack of

follow-up can result in a readmission which might have been avoided by a more timely intervention.

The problem is made worse by the practice of some physicians who restrict their engagement with charity care patients to a single ED encounter, limit the range of services they are willing to perform, or fail to manage the clinical condition to conclusion. Reimbursement and liability concerns are likely drivers, but fall short of excuses for such behaviors, which in extreme cases can amount to the virtual “abandonment” of the patient. This increases clinical costs, creates liability exposure, may place patients at increased risk and degrades health care quality.

There are at least three key components to establishing a continuum of care that are within the existing capabilities of New Jersey’s acute care facilities. Hospitals can establish guidelines to assure patients are admitted to the most medically appropriate service, insist ED physicians manage patients to an appropriate point of transfer, and ensure discharge procedures provide for appropriate follow-up, after-care, or outpatient services.

Hospitals traditionally do not question admission to a primary care provider’s service or make an independent determination whether another service or specialist care would be more appropriate and efficient. However, procedures that ensure patients are admitted to the appropriate service will increase their likelihood of receiving well-managed treatment from the onset of care through discharge or transfer. Consultation and/or recruitment of other providers should be coordinated by the appropriate admitting physician. In situations where hospitals lack needed specialty resources, regional relationships could fill the gap.

Hospital policies must clarify the scope of physician responsibility for all ED cases, and articulate unambiguous professional, ethical and legal standards to ensure patients receiving treatment in the ED service are managed through to clinical resolution and appropriately stabilized, discharged or transferred. Stronger inducements, including legislative mandates, may be necessary if such encouragements prove insufficient.

Utilization of appropriate post-discharge care can mean better outcomes, more compassionate care, and greater cost-efficiency. This may include local or regional access to long term ventilation units, vent/dialysis units, long-term acute care facilities (LTACs), nursing homes, and hospice care. Discharge procedures should encourage such choices and efforts should be made to reduce or eliminate any financial barriers that may inhibit considering such alternatives.

Managing the continuum of care for the highest cost diagnoses (DRGs) may offer the best opportunity for realizing a measurable benefit from a coordinated approach. CHF (congestive heart failure) is a good example, representing one of the most common and costliest DRGs. Coordination of in-patient care and outpatient support through specialists, anticoagulation and/or CHF clinics is likely to prove a readily available, cost-effective strategy.

### **Recommendation**

- Encourage coordinated care through a system of appropriate incentives and standards for achieving measurable results that will at a minimum:
  1. Assure patients are admitted to the most medically appropriate service,
  2. Require ED physicians to manage patients to an appropriate point of transfer, and
  3. Establish discharge procedures that provide for appropriate follow-up.
- Each acute care hospital should develop specific guidelines for implementing coordinated care.

## **IX. Information Technology Systems to Promote High Performance**

Health IT systems hold great potential to improve the real-time availability of data to enhance the clinical and financial performance of acute care hospitals. Physician services would be enhanced through ready access to clinical data to optimize clinical decision-making. Hospitals would be better able to monitor the performance of individual clinicians as well as their own institutional performance relative to peer institutions.

The Commission strongly endorses efforts to increase the diffusion of health IT systems and efforts to exploit current resources. Further discussion can be found in a separate chapter on information technology later in this report (Chapter 16).

### **X. Conclusion**

The crisis in acute care facing many communities and institutions in New Jersey is profoundly affected by the relationship between the hospitals that provide access to services and the physicians who provide the care. While these stakeholders share many interests and goals in delivering effective and high quality medical care, in too many instances financial pressures, structural

inefficiencies, imperfect information and irrational patterns of traditional practice, resource allocation and use defeat or deflect the achievement of these ends. In this chapter, the Commission called for better alignment of payment incentives for physicians and hospitals, more evenly applied regulations for ambulatory surgery centers relative to hospitals, transparency of performance measures and cost data, initiatives to improve efficiency of hospital operations, and incentives to better coordinate care across the full continuum. These recommendations can be part of the answer to rescuing New Jersey's most at-risk institutions, bringing quality care to underserved communities, and raising the level of health care available to all persons seeking it within the State.

