MISSOURI HOSPITALIST SOCIETY

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Hospitalist Update

The 2010 SHM/MGMA Hospitalist Survey: an Update

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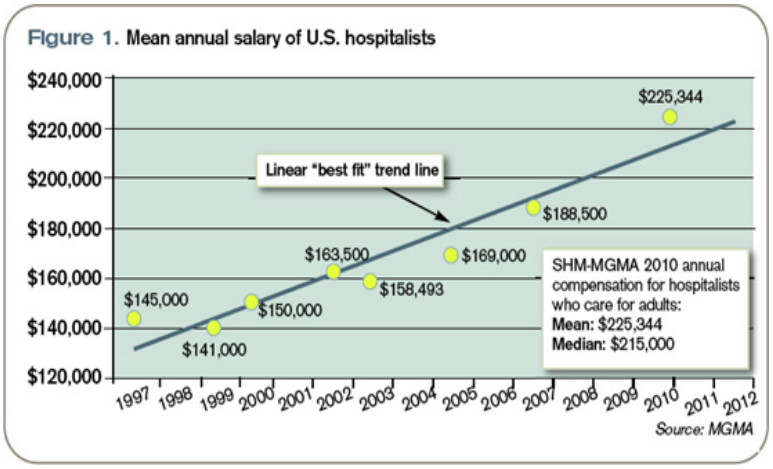
The Medical Group Management Association and the Society of Hospital Medicine have teamed up to survey hospitalists and hospital medicine groups on compensation and productivity measures. Officially titled "SHM/MGMA State of Hospital Medicine: 2010 Report Based on 2009 Data," it is an update of the most recent 2008 survey.

The current survey respondents consist of 4211 hospitalists in 433 hospitalist groups, from Internal Medicine,, Family Medicine and Pediatrics. One major difference from past surveys, noted in this report, is that only 1% of physician respondents were academic hospitalists as compared to 25% in past surveys; the MGMA and SHM plan to survey academic hospitalists separately in the fall of 2010 with a report due in 2011. Excluding academic hospitalists makes this report less relevant for us in academia but provides a more accurate picture of the hospitalist market in general.



As illustrated above, the salary figures in the recent survey report show that hospitalist compensation continues to grow. The median total compensation (not including benefits) of approximately $215,000 rose almost 20% from the 2008 SHM survey. Salary data was reported in many different ways, including by (continued)

(continued) specialty, region, practice ownership and hospital type. Most of the data was not surprising, as follows: there were considerable differences in compensation by region, hospitalists in practices owned by hospitals made less than those in physician-owned practices and hospitalists in academic centers made less than those in the private sector. Family practice hospitalists earned slightly higher compensation, near $218,000 per year, while pediatric hospitalists continued to lag behind at approximately $160,000 of total compensation per year.

However, the biggest headlines made by the 2010 survey were the data which showed that hospitalists who are paid less than half of their total compensation in base salary ended up with the highest total compensation and the highest level of productivity as measured by work RVU (WRVU). These data are not particularly surprising, since they indicate that hospitalists are capitalists too. What the data didn't show was how the extra WRVUs were obtained. Did these hospitalists see more patients per day or did they agree to work more clinical weeks per year, or perhaps both? What was their practice model—did they mainly work solo or with non-physician providers?

Furthermore, the data brings to mind a broader question: what compensation model is appropriate for hospitalist practice? The most important unanswered question: what about quality? How are these hospitalists ensuring patient safety? Do they have time to work on quality improvement, clinical protocols and standardization of care? If highly productive and heavily incentivized hospitalists cannot answer these questions to the affirmative, then the hospital may not be correctly aligning their hospitalist incentive program with the institution's duty to ensure quality of care and safety for their patients. Finally, under new compensation models, including the center for Medicare and Medicaid Services' (CMMS) proposed Accountable Care Organization (ACO) demonstration, hospitals and physicians will be receiving bundled payments for care episodes. Under these new models, the value that hospitalists bring to a hospital will change to the delivery of high quality and efficient care, rather than patient volume. However, bundled or capitated payment models may also reduce a hospitalist's incentive to be clinically productive.

This brings us back to our question: What compensation model is appropriate for hospitalist practice? In order to align hospitalists' clinical productivity incentives and the hospital's quality/safety goals, a blended model of incentives seems to be most appropriate. What will this model look like? Most likely, it will include productivity incentives, including WRVUs with pre-specified benchmarks, efficiency incentives for length of stay improvements and evidence-based quality measures. The specific measures that are used will need to be negotiated between each hospital and their hospitalist group. In addition, under bundled payment models, hospitalist practices will want to track their contribution to cost savings and build savings incentives into the agreement as well.

So, while the SHM/MGMA State of Hospital Medicine 2010 Report may not be directly relevant to those of us in academic medicine, its data certainly provides food for thought for all hospitalists and their hospital administrations. Hopefully, it will prompt us to consider the VALUE that hospitalists bring to the hospital, including efficiency of care as well as quality and safety improvements. Based on these considerations, the hospitalists can work with their hospital to negotiate a compensation program that aligns incentives with the broader goals of the hospital.

CASE OF THE MONTH

Sarah Smitherman MD

Initial Presentation:

A 25 year old previously healthy female presented with a sore throat of three days duration. Associated symptoms included dysphagia and odynophagia but no drooling was reported. Her pain progressed to the point that she refused all solid foods and liquids. She also complained of neck pain and swelling that limited the range of motion in her neck. Fever had ranged from 102-104 degrees F. She had a "raspy" voice but did not complain of respiratory difficulty, stridor or wheezing.

Initial exam revealed an erythematous posterior pharynx and a midline, non-edematous uvula. The epiglottis was not visible due to a significantly swollen and tender posterior third of her tongue. She had bilaterally enlarged cervical lymphadenopathy (> 1cm) of both the anterior and posterior chains. Her neck range of motion was limited by edema and tenderness. Respiratory exam was negative for stridor, wheeze, crackles or rhonchi.

Differential Diagnosis:

Bacterial pharyngitis can be from streptococci, staphylococci, diphtheria, meningococci or gonococci. Viral pharyngitis can be secondary to EBV, CMV, adenovirus, parainfluenza and primary HIV infection. Other causes of severe dysphagia and odynophagia include epiglottitis or abscesses (tonsillar, peritonsillar or retro-pharyngeal). Congenital defects of the thyroglossal duct and pharyngeal cleft cysts must also be considered in a patient with significant neck swelling and tenderness.

Evaluation and Management:

The patient's lab data revealed a WBC of 22,500 with 80.4% granulocytes. Streptococcal pharyngitis was ruled out with a normal rapid strep test and a negative throat culture. Blood cultures were negative. A monospot was performed and was positive.

A CT of the neck was obtained to look for a possible abscess; it demonstrated a 2.1 x 2.7 cm soft tissue enhancement at the base of the tongue. The epiglottis was not clearly distinct from this swelling and there was concern for epiglottitis; the CT also revealed significant airway compression, with the narrowest point measuring only 6 mm. Emergent ENT consultation was requested and a transnasal fiberoptic flexible laryngoscopy was performed at the bedside. Engorgement of the lymphoid tissue at the base of the tongue was encroaching on the epiglottis but the epiglottis itself was not inflamed.

While cultures were pending, the patient received empiric coverage with vancomycin and ceftriaxone and completed three doses of IV dexamethasone due to concerns for airway obstruction; a difficult intubation kit was kept at her bedside. The patient was closely monitored in the Stepdown Unit with the head of her bed elevated and continuous pulse oximetry in place. By the third hospital day, the patient had improved significantly; her lymphadenopathy had decreased, normal range of motion in her neck was restored and she was tolerating an oral diet.

Learning Points:

Epiglottitis in adults is a rare occurrence but should be considered when faced with a clinical presentation such as this; our patient had the typical warning signs of epiglottitis, including odynophagia, dysphagia and change in voice quality. Epiglottitis is a medical emergency because of its rapid onset and potential for compromise (cont)

(continued) of the airway. Lateral neck radiographs are not as reliable for diagnosing epiglottitis in adults as they are in children. The evaluation of possible epiglottitis in adults is best performed by the use of transnasal fiberoptic flexible laryngoscopy, as was done in our case. The agent of epiglottitis was formerly Haemophilus influenza B but, in the post HIB vaccination era, it is primarily caused by Staphylococcus aureus and Streptococcus pyogenes. Treatment of epiglottitis should include broad spectrum antibiotics and corticosteroids; if treated appropriately, most adult patients recover without the need for intubation.

While this patient did not have epiglottitis, she had significant EBV associated lymphadenopathy. She was diagnosed with EBV via a positive Monospot; in the context of mononucleosis-like symptoms, the Monospot sensitivity can reach 85%, with a specificity of 94%. However, 25% of adults may have a negative Monospot during the first week of infection. The Monospot sensitivity is further reduced in children under 12; in this group, only 25-50% of the Monospots are positive. Had the Monospot been negative in our patient, further testing would include screening for either EBV specific antibodies (IgG and IgM) or EBV nuclear antigen proteins.

Airway obstruction in EBV infection is rare (<5%), with young children at higher risk than adolescents or adults. When there is concern for airway compromise, a CT of the head and neck should be performed to look for concomitant bacterial abscess formation. Until imaging is obtained, empiric antibiotics should be initiated but steroids should be withheld until abscess formation has been ruled out; upper airway obstruction is one of the few indications for steroid therapy in EBV management. When indicated, a three day course of dexamethasone or methylprednisolone is recommended; subjective improvement often begins within 24 hours. Some advise caution regarding the use of steroids in patients with EBV infection because of the potential for contributing to subsequent EBV associated malignancies.

Summary:

EBV virus can be a significant cause of head and neck lymphadenopathy which may lead to airway compromise in severe cases. Our patient improved significantly after receiving empiric antibiotics and corticosteroid therapy; the steroid therapy was brief and the antibiotics were discontinued once epiglottitis and abscess were ruled out. The patient was discharged to home on the third hospital day and continued to improve during the course of her outpatient care.

References:

Garantziotis, S. et al., Critical Care of the Head and Neck Patient, *Critical Care Clinics* 2003; 19:73-90

Jenson, H., Acute complications of Epstein-Barr virus infectious mononucleosis, *Current Opinion in Pediatrics* 2000; 12:263-268

Luzuriaga, K. and J. Sullivan, Infectious Mononucleosis, *New England Journal of Medicine* 2010; 362:1993-2000

FROM THE JOURNALS

LES HALL MD

Feasibility study of a systematic approach for discontinuation of multiple medications in older adults

Garfinkel, D. et al., Arch Int Med 2010; 170(18):1648-1654

Interesting study addressing the issue of polypharmacy in older adults. Mean age of patients in the study was 82.8 years, with patients taking a mean of 7.7 medications at the study initiation. Recommendations were made to discontinue 58% of drugs (4.4 drugs per patient). Only 2% of the medications were restarted due to symptom recurrence and no significant adverse events or deaths were attributed to having discontinued the medications. Indeed, 88% of patients reported global improvements in their health.

Patient-level meta-analysis: Effect of measurement timing, threshold and patient age on ability of d-dimer testing to assess recurrence risk after unprovoked venous thromboembolism.

Douketis, J. et al., Ann Int Med 2010; 153:523-531

Meta-analysis of seven studies following patients with recent unprovoked DVT for a mean of up to 27 months after the DVT. Those with elevated d-dimer levels had a greater than two-fold risk of recurrent DVT compared to those without d-dimer elevation (8.8 per 100 patient-years vs. 3.7 per 100 patient-years). This suggests that measurement of d-dimer in such patients may contribute to risk stratification when deciding on the risks vs. benefits of long term anticoagulation.

High-dose vs. non-high dose proton pump inhibitors after endoscopic treatment in patients with bleeding peptic ulcer.

Wang, C. et al., Arch Int Med 2010; 170(9):751-758

Meta-analysis of over 1100 pts from seven studies looking at benefits of PPI regimens in bleeding peptic ulcers. Use of high dose PPI did not result in lower rates of rebleeding, surgical intervention or mortality when compared to low dose regimens. In a subsequent issue (Arch Int Med 2010; 170(18):1697-1700), several letters questioned the conclusions of this study, stating that current evidence could not lead to claim of equivalence between low dose and high dose regimens. This is an important clinical question and more data is needed to resolve the issue with certainty.

Patient handovers within the hospital: translating knowledge from motor racing to healthcare.

Qual Safety in Health Care 2010; 19:318-322

A qualitative study examining key lessons from Forumula 1 racing teams, applying them to patient hand-offs in health care. Key common themes included: 1. proactive learning with briefings and checklists to prevent errors, 2. active management using technology to transfer information and 3. post hoc learning from the storage and analysis of electronic data records

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ID CORNER WILLIAM SALZER MD

C DIFFICILE—AGAIN!

The most recent Annals of Internal Medicine (10-5-10) has a nice *In the Clinic* review of C Diff (Volume 153, ITC4). These reviews are concise, to the point and well referenced.

http://www.annals.org/content/153/7/ITC4-1.full.pdf+html

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MISSOURI HOSPITALIST CALENDAR

Chest 2010, October 30-November 4, 2010, Vancouver, BC; register via their website: http://www.accpmeeting.org

8th Galaxy of Gastroenterology: Topics in Gastroenterology for the Specialist and Primary Care Physician, November 5-6, 2010, Ritz-Carlton Hotel, St. Louis; Washington University School of Medicine; information and registration via: http://cme-online.wustl.edu/gi **LOCAL**

Congestive Heart Failure Update, Saturday, December 4, Eric P. Newman Education Center, Washington University Medical Center; register online at: http://cme.wustl.edu or call 800-325-9862 **LOCAL**

43rd Annual New York Cardiovascular Symposium: Major Topics in Cardiology Today, December 10-12, 2010, Hilton, New York; for information and registration visit: http://www.cardiosource.org/acc and click Meetings-ACC live events

Renal Complications in the ICU, Society of Critical Care Medicine, March 10-11, 2010, Atlanta, Georgia; for information and registration visit: http://www.sccm.org/Conferences

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Please direct all comments, ideas and newsletter contributions to the Editor:

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Please forward this newsletter to Hospitalists that you might know!