Certification in Hospital Medicine Is on Its Way

BY BRUCE JANCIN
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DALLAS — Board certification for hospitalists is coming—and most likely will initially take the form of a Recognition of Focused Practice granted by the American Board of Internal Medicine, according to speakers at the annual meeting of the Society of Hospital Medicine.

This Recognition of Focused Practice (RFP) in Hospital Medicine would be the first ABIM credentialing that doesn't require discrete formal training, relying instead on practice-based learning. The plan is for hospitalists to tap into the ABIM's existing maintenance of certification (MOC) mechanism, which every ABIM-certified physician already must go through periodically to demonstrate ongoing competence and a commitment to continuous lifelong learning, explained ABIM board of directors member and past SHM president Dr. Robert M. Wachter, professor and associate chairman of medicine at the University of California, San Francisco.

The ABIM, which had previously endorsed the concept of an RFP in Hospital Medicine, voted unanimously in early June to approve recommendations by a board subcommittee that Dr. Wachter chairs. The RFP plan goes next to the American Board of Medical Specialties, composed of 24 member boards, for final approval.

Although a handful of hospital medicine fellowships exist and some internal medicine residency programs offer a hospitalist track, such training isn't the norm and is unlikely to become so anytime soon. But the ABIM has established a template for recognition of new fields of internal medicine in the absence of discrete training. The criteria are contained in the ABIM's New and Emerging Disciplines in Internal Medicine II (NEDIM II) report. Hospital medicine is the first candidate for certification under its auspices. Others that may follow include HIV medicine and ambulatory internal medicine, according to Dr. Wachter.

In recent decades, boards have certified new specialties formed around novel procedures such as cardiac electrophysiology, or special populations such as geriatrics and palliative care medicine. Hospital medicine is an example of a site-specific medical specialty defined largely by the setting in which the work takes place. Emergency medicine and intensive care medicine fall within the same category.

Here's what hospitalist certification through the ABIM is likely to look like:

A candidate will have to be trained and board certified in internal medicine and must practice as a hospitalist for 3 years before applying to enter the MOC pathway seeking the RFP. The candidate must demonstrate a focus on hospital medicine by meeting a patient volume requirement and providing leadership of quality improvement projects.

Having met that threshold, the physician then enters into the self-evaluation programs and practice improvement modules that make up the MOC, which will be tailored for hospitalists. Unlike general internists, who have to go through the MOC process every 10 years, it's likely that hospitalists will be on a 3-year cycle, according to Dr. Wachter.

After completing the MOC, the candidate becomes eligible to take a secure exam. The test will cover core content in internal medicine—including ambulatory care—that every internist should know, but the emphasis will be on hospital medicine. "More sepsis, less osteoporosis," Dr. Wachter said.

Upon passing, the physician will earn the RFP in Hospital Medicine sheepskin.

Down the line—perhaps in a decade—hospital medicine might very well evolve into a separate field within internal medicine, with its own residency tracks or fellowship training, but that's an issue for another day, he added.

Society of Hospital Medicine president Dr. Mary Jo Gorman said the SHM began investigating certification in 2004. Milestones along the way included the discipline's continued eye-catching growth—it is the fastest-growing field in the history of medicine, having rocketed from several hundred members a decade ago to 20,000 today—along with publication of a document defining the core competencies in hospital medicine and the launch of the society's official peer-reviewed Journal of Hospital Medicine, noted Dr. Gorman, CEO of Advanced ICU Care, St. Louis.

She said the SHM has met for "vigorous discussions" with other stakeholders in certification, including the American College of Physicians (ACP), the Society of Critical Care Medicine, the American College of Chest Physicians, and the American Thoracic Society. Despite concerns expressed within the ACP about the potential effects of the plan to develop the RFP in Hospital Medicine, ABIM and ACP leaders have expressed support for the process, in conjunction with development of a parallel RFP in Comprehensive Internal Medicine. The focused practice proposal still awaits approval by the American Board of Medical Specialties, Dr. Christine K. Cassel, president and CEO of the ABIM, and Dr. John Tooker, Executive Vice President and Chief Executive Officer of the ACP, said in a joint statement.

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Under the proposed certification program, hospitalists probably will have a 3-year cycle for their recertification, according to Dr. Robert M. Wachter of the ABIM.

Prior to ABIM's approval of the certification proposal, Dr. Wachter predicted that it would pass because hospital medicine meets the ABIM's NEDIM II criteria and the specialty can show that hospitalists improve efficiency and may also improve quality of care, although the quality advantage is supported at this point by suggestive rather than compelling evidence.

"The board thinks the world of what all of you do for a living. I've never heard anything at any ABIM meeting other than full support for the growth of the hospitalist field," he told the packed hall at the SHM meeting.

The SHM has partnered with ABIM because roughly 90% of practicing hospitalists are internists. But a family physician in the audience who practices hospital medicine asked where all of this leaves him as well as the pediatrician-hospitalists. Dr. Gorman replied that the American boards of family medicine and pediatrics are watching the ABIM certification proposal closely and—if it's passed by the American Board of Medical Specialties—are likely to create similar pathways.

"Our biggest problem at SHM is everybody wants to partner with us," said SHM chief executive officer Dr. Laurence Wellikson, who characterized hospital medicine as "the X-Games of medical specialties."

Today hospitalists work in well over 2,600 hospitals. Currently, 40% of community hospitals have hospitalists, up from 29% in a 2003-2005 survey.

"Who cares that hospitalists are there 24/7?" he asked, ticking off the answer: "Primary care physicians, surgeons, orthopedists, emergency physicians, internists, patients, subspecialists."

At the close of the update, Dr. Gorman asked the audience if they favored the certification process they had just been briefed on. In an impressive display, the hands of literally all of the roughly 1,000 attendees shot up. When she next inquired who was not interested in utilizing the certification process, not a single hand could be seen. ■

PQRI Reporting Will Require Some Use of Coding Modifiers

Physicians who choose to participate in Medicare's pay for reporting program do not have to satisfy quality indicators to receive a bonus. But in some cases, they will need to cite why they did not follow evidence-based guidelines.

Under the Physician Quality Reporting Initiative (PQRI), which at presstime was slated to begin July 1, reporting for certain measures will include adding a coding modifier explaining why a service was not performed. For example, the service may not have been provided because it was not medically indicated or the patient declined.

The PQRI is a voluntary program that allows physicians to earn a bonus payment of up to 1.5% of total allowed Medicare charges for reporting on certain quality measures. The program will run from July 1 through the end of the year. CMS officials have selected 74 quality measures and physicians are expected to report on between one and three measures, depending on how many apply to them.

When reporting on measures, physicians must include a CPT-II code or G-code. Some measures may also require that physicians add a modifier to the CPT II code if the service was not provided. These modifiers are not used when reporting G codes. The CPT-II modifiers include performance measure exclusion modifiers and a performance measure reporting modifier. For example:

► Modifier 1P is used to show that the service was not indicated or is contraindicated for medical reasons.

► Modifier 2P is used to indicate that the service was not provided for patient reasons, such as the patient declining or religious objections.

► Modifier 3P is used to indicate that the service was not provided for systems reasons such as insurance coverage limitations or a lack of resources to provide the service.

► Modifier 8P is a performance measure reporting modifier and indicates that the action was not performed and the reason has not been specified.

Specific instructions on when to use a modifier in the 2007 PQRI Specifications Document, which is available online at www.cms.hhs.gov/pqri. CMS officials also plan to issue a detailed handbook on how to implement PQRI measures in clinical practice, which will include when to use CPT-II modifiers.

—Mary Ellen Schneider