

## Hospital medicine's management shuffle

Shifting management strategies may mean a rough ride for physicians

by Bonnie Darves

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While the explosive growth of hospital medicine over the past 10 years has been anything but dull, a recent run of consolidations among large hospitalist companies and re-alignments within smaller programs may signal the field's most turbulent era yet.

The past 12 months, for instance, have seen nearly a half-dozen mergers and dozens of acquisitions within national hospitalist companies. Big players like IPC-The Hospitalist Company, Cogent Healthcare and TeamHealth Hospital Medicine are all acquiring practices and signing new deals at a dizzying pace. And on a regional level, mergers are giving companies such as Sound Inpatient Physicians in the Western U.S. new critical mass and clout.

But while national and regional hospitalist companies are growing, that's only part of the story. Even as some hospitals are turning to outside companies for help in running their hospitalist programs, others are taking the opposite approach, deciding to dismantle programs that have always been outsourced and bringing them in-house.


### Re-inventing programs

Industry experts say that hospitals that have decided to bring their hospitalist programs in-house want to better align the program with their mission. By taking more control over issues like recruiting and staffing, these hospitals want to not only make hospitalists a more integral part of the institution, but improve what they see as poor performance.

And the hospitals and hospitalist groups that are turning to outside companies for help are hoping to take advantage of the economies of scale these large organizations offer. Partnering with a large vendor can give cash-strapped, smaller hospitalist programs quick access to IT systems and other tools they could never afford on their own.

Why are so many programs making dramatic changes at the same time? Industry experts say that as hospital medicine matures, hospitals everywhere are beginning to realize that their hospitalist programs could be doing more.

"These systems have reached the point of understanding that their hospitalist programs are much more than glorified physician admitting panels, that many other objectives can be reached," says Steven Nahm, vice president of The Camden Group in El Segundo, Calif.



**Hospitals now bringing programs in-house want more local control over both the number of hospitalists and the scope of services.**

And Martin Buser, MPH, co-founder of the hospitalist consulting firm Hospitalist Management Resources LLC, which has offices in San Diego and Colorado Springs, Colo., attributes much of the change to programs trying to fix the problems that have surfaced as a result of growth.

"A lot of the early adopters slumped in programs because they thought it was an interesting solution to the ED unassigned problem," he explains, adding that many programs just didn't do the proper planning. "When the program started growing and adding services, doubling or tripling in size, the program took on a life of its own, often without the proper infrastructure and financial support." That runaway growth, he adds, is prompting many programs to either start over from scratch or outsource.

### **Big players**

For a clear indication that hospital medicine is entering a new era, look no further than the rash of high-profile mergers and acquisitions of the past year.

Last summer, for instance, the Knoxville, Tenn.-based TeamHealth acquired Florida Acute Care Specialists, with its 100-plus hospitalists in Florida and Puerto Rico. That brought TeamHealth's total physician roster to around 400.

And earlier this year, Sound Inpatient Physicians, which is based in Tacoma, Wash., expanded into two new states when it merged with Excelsis Healthcare Inc. in Phoenix and Inpatient Services PC in Denver. The mergers augmented Sound's ranks by more than 100 physicians, almost doubling the size of the company.

Those developments show that even well-established, well-functioning programs sometimes opt for new management to meet dual needs: infrastructure for continued growth, and information technology. Those were among the reasons why Inpatient Services, with 35 hospitalists and a nearly decade-long foothold in the Denver market, decided to merge with Sound a few months ago.

"We were facing continued growth, and to manage that successfully we needed dramatically better infrastructure and support," says the group's co-founder M.A. Williams, MD, who is now chief medical officer for Sound's Rocky Mountain region. "We thought long and hard about whether we could get smaller and be better—but given the current environment, we didn't think we could do that."

For similar reasons, Hospital Specialists of Georgia, a 20-hospitalist group in Macon, last year turned over management services for its largest client, Medical Center of Central Georgia, to Cogent. The group retained a private-practice group structure for its other two hospital clients.

"When the medical center looked at the work we were doing, they thought having someone come in and help us grow was important," recalls Eddy Young, MD, the group's president. The group was handling nearly a third of the medical center's admissions, and the center sought to increase that number, which the group couldn't readily do without better support.

The group's need for data management, especially as performance measurement becomes more prevalent, was becoming a complicated—and expensive—proposition.

"We realized that it would take many hundreds of thousands of dollars to buy the IT, and we didn't have a lot of extra money," he says. "It just made sense to partner with somebody."

### **Coming in-house**

At the other end of the spectrum are hospitals that, after several years of outsourcing their hospitalist program, decide instead to go it alone. Many of these hospitals figure that they've learned from their former partners—and the industry as a whole—about how programs can or should be operated. Perhaps more importantly, because the hospitalists are now such a key part of hospitals' inpatient care and competitive positioning strategy, hospitals feel they need to bring the program under local control.

A good example is Kadlec Medical Center, a 188-bed facility in Richland, Wash. The hospital's administration decided in February 2006 to discontinue its contract with a national company and start its own program. The hospital wanted more control over both the number of hospitalists and the scope of services.

"The issue wasn't the physicians. We would have retained them if we could have," says the hospitalist group's executive director Janice Roach, who notes that the contract's restrictive covenant prevented the former hospitalists from staying.

Instead, the medical center created a limited liability company to employ its hospitalists and appointed a physician-managed board for governance purposes. Now, little more than a year later, the group has eight hospitalists, up from three when the program was outsourced.

When the 227-bed Lake Cumberland Regional Hospital in Somerset, Ky., made the decision last fall to bring its outsourced program in-house, a primary goal was to achieve more local control and boost the facility's standing as a preferred referral center.

Robert Blankenship, MD, medical director of the recently formed Cumberland Hospital Physicians, says that while the previous program was well-staffed, it did not receive enough financial support from the hospital. In addition, it was not well-supported by the medical staff, in part because the management company operated it without a local leadership presence.

"The program had good doctors who worked hard," Dr. Blankenship says. "But it didn't have enough local leadership, and it didn't have the buy-in from the medical community."

Now six months into the new arrangement, relations between hospitalists (two physicians from the former program stayed on) and medical staff have improved, and the hospital and hospitalists are working together more closely.

### **Selling physicians on the switch**

According to program leaders who have decided to either bring a program in-house or contract with a hospitalist management company, physician performance rarely influences their decision. But in the current climate, it is often physicians who are hardest hit by change.

For programs that are merged or acquired, helping hospitalists deal with that change while avoiding undue disruption is not easy. In Denver, Dr. Williams recalls, the biggest challenge was making the economic case.

"The biggest feat for us was explaining to our physicians our current state of affairs," he says, "down to the nuts and bolts of how we get paid and how we want to work."

The group also had to convince its overworked hospitalists that the merger would ultimately improve services while reducing patient load and the number of daily encounters. Before the merger, the group was subsisting on managed care contracts and fee for service, an arrangement that sometimes translated into hospitalists caring for 18 to 20 patients a day.

And in Macon, Dr. Young was able to generate physician support for the new arrangement with Cogent, in part because it is a partnership, not a merger. Under a complex arrangement, Cogent will supply information technology and infrastructure support, such as billing services.

Dr. Young says that he pointed out that Cogent would provide sorely needed nursing help, which in turn would enable the hospitalists "to move patients through the system more efficiently." He also sat down with each of the hospitalists to explain how things would improve and to find out what was important to them during the transition.

He says that some hospitalists were concerned about the potential loss of clinical autonomy, while others feared that they might not have the work schedules they needed for personal or family reasons.

### **Evolving employment models**

While shifts in management have a big impact on hospitals and individual physicians, they are also changing hospitalist employment models.

Typically, hospitalists who work for national companies have been brought on as employees. But as the marketplace shifts and competition for a scarce talent pool intensifies, even long-established companies find they have to be creative to suit the times.

A case in point is Cogent, a national company that operates more than 30 programs in 20 states. (The company, which has been based in Irvine, Calif., since it was founded in 1997, announced last month that it was moving its headquarters to Nashville.)

As recently as last year, the company planned to employ all the hospitalists in any program that it started up or took over, as it has done historically. But as Cogent's chief medical officer, Ron Greeno, MD, explains, the company has learned that it needs to be flexible.

"In 2007, we expect that in half of the programs we build, the hospitalists will not be Cogent employees," says Dr. Greeno. "In most situations, they'll be either hospital employees or employees of their own groups."

For example, Cogent is now partnering with some for-profit hospital systems in which the physicians remain hospital employees while Cogent runs the program. "It's basically a management services organization [MSO] product, in which we overlay our management services on a hospital-employed group," Dr. Greeno explains.

He adds that Cogent plans to do an increasing number of such partnerships, which have this advantage: Physicians don't have to end their contracts and re-contract with a new entity. "Take out that one piece," Dr. Greeno says, "and it makes that transition easier."

In other arrangements, Cogent and private groups form a limited liability corporation that provides the hospitalists, while Cogent delivers the management services.

Likewise, Sound, which now employs more than 250 hospitalists and operates programs in six states, has begun venturing out of its traditional program-startup model by taking over an IPA-model program in Ventura, Calif.

"The biggest transition there was getting the doctors to believe that our model—with a low number of encounters and 15 shifts per month—was possible, while still maintaining an outstanding compensation package," says the company's president and cofounder Robert Bessler, MD.

And Sound has also implemented payer-driven hospitalist models in Phoenix, which it plans to introduce in other markets as well. Such models will "also allow us to keep our encounter numbers and days worked per month low," Dr. Bessler says.

### **Change as the new constant**

In the meantime, say industry leaders and observers, hospitalists can expect change to be a constant as the market evolves and hospitals try different management structures to suit their changing needs.

"Even some of the big hospitalist groups are struggling, primarily because of rapid growth and high demand for hospitalists," explains Mr. Buser. In the case of hospital-spawned programs, hospitals and program directors now find themselves in trouble because they didn't anticipate the leadership or management challenges. "They've got to retool with management training or throw in the towel," he says, which means more change to come.

Cogent's Dr. Greeno agrees. "This is an incredibly dynamic marketplace and environment." He adds that many programs just aren't working the way they should, because of lack of support or resources or because of the wrong physician compensation plan.

"A lot of people are starting over," he says, "and we'll see a lot of that for many years, I think."

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### **Tips for weathering management transitions**

As hospitalist programs across the country look for ways to re-invent how they do business, that trend is creating confusion for program directors and hospital administrators. But hospitalists caught in the crossfire are getting on-the-job training in change management.

Hospitalist Bijo Chacko, MD, is a good example. Now medical director of the hospitalist program for Central Brooklyn Medical Group, large multispecialty practice in Brooklyn, N.Y., Dr. Chacko spent his first 20 months as a practicing hospitalist in a national group.

In that first position, Dr. Chacko says, he endured the transition between the old and new programs. While the new program wanted to hire the hospitalists, the management group that was losing the contract enforced a restrictive covenant to prevent its former employees from staying on.

"Things got a little tense for awhile," he recalls, while the two parties worked through contractual issues such as tail coverage.

Eventually, the parties reached a settlement, but there was disruption and frustration. "I learned that you must maintain your composure regardless of the change," he says, "because at the end of the day it's about patient care. You have to ensure that continuity exists."

To help maintain that continuity, industry experts, program directors and hospitalists suggest these strategies to prepare for and weather a transition:

- **Stay informed—and involved—in discussions.** Young hospitalists may think it's inappropriate to press for details when a management shift is in the offing. But they need to ask questions to ensure that the prospective program and operational structure will suit their professional and personal needs. "You'll never be wrong by asking what's on the horizon, to figure out whether the change will be aligned with what you value," explains Dr. Chacko.

For example, a management change may mean that hospitalists who are used to working 12-hour shifts with one group might have to assume 24-hour call duty with a new one. "That may be enough for you to re-evaluate your current position and start looking elsewhere," Says Dr. Chacko.

Eddy Young, MD, president of the Macon-based Hospital Specialists of Georgia, agrees that hospitalists shouldn't be shy about asking how a change will affect them. "They need to ask how the change will affect their responsibilities, if they will now be covering codes, for example," he points out.

- **Engage hospitalists in the transition.** While this should be a given, it doesn't always happen—or it may not happen in a genuine manner, says Robert Blankenship, MD, the medical director of Cumberland Hospital Physicians in Somerset, Ky. Dr. Blankenship was retained to bring a formerly outsourced, poorly functioning program in-house last October.

"It's very important to show the hospitalists that you're on their side—not the dark side—and to seek their input on what they want the group to be," he says. Programs also need to listen carefully to what hospitalists feel wasn't working under the old regime.

According to Dr. Chacko, physician input may be the glue that holds the group together during a transition. "As a group, having a shared mission and vision becomes something that, regardless of a change in management or leadership, the group will strive for," he says.

- **Communicate openly with hospital medical staff.** Ironically, medical staff members who initially resisted implementing a hospitalist program may be the most anxious about a possible shakeup in services they now rely on.

To deter speculation and prevent strained relations, inform the medical staff early of the reasons for the transition, says Steven Nahm, vice president of the consulting firm The Camden Group in El Segundo, Calif., and keep them abreast of plans for the new implementation.

It's also important to ensure that the new or replacement program has the medical staff's buy-in, advises Janice Roach, executive director of Kadlec Medical Associates, the hospitalist group affiliated with Kadlec Medical Center in Richland, Wash. One way to improve buy-in, she says, is to "keep medical staff informed of the hospitalist recruitment progress."

● **Don't count on the grass being greener.** Industry analysts agree that shifting and consolidation within hospital medicine will persist.

The hospitalist who leaves one program to avoid a rocky transition may find herself in the same boat three months down the road, cautions Ron Greeno, MD, Cogent Healthcare's chief medical officer. If the environment is agreeable, he says, consider staying put.

"There will continue to be a lot of change, so don't get spooked and go somewhere else if you like your hospital and the community," Dr. Greeno says. "Give it a chance; you may end up with a better program and work environment."