Tips to creating a successful hospitalist program

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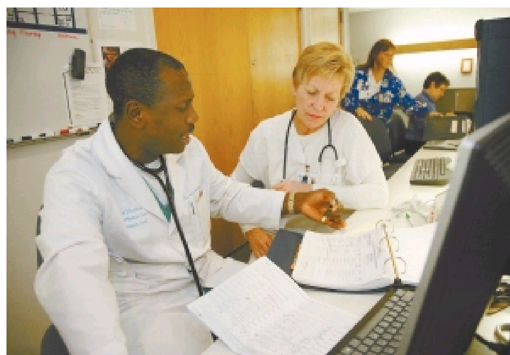
By Tom Reinke

New hospitalist programs are being developed rapidly—2,000 programs in the 10 years since the concept was born. The programs vary widely by market and hospital, but there are some common pitfalls to avoid. Following are some suggestions from experts in the field on the elements that shape a successful program.



Hospitalist Alexander Johnson, MD, of Cogent Healthcare receives a patient update from Genesis Neuroscience nurse Judy Bergren, RN. The hospitalist team at Genesis Medical Center in Davenport, Iowa, coordinates the patient's care across all hospital departments throughout their stay.

What drives your program? It is important to remember what you hope to achieve or what problems you hope to solve by creating a hospitalist program. Robert M. Wachter, FACP, a hospital medicine pioneer at the University of California, San Francisco, cited these examples of forces that drive hospitalist programs:

- requests from the medical staff to handle unassigned patients,
- the hospital's interest in shortening length of stay,
- referred inpatients from low-volume admitters,
- surgeons' requests for consultation or comanagement,
- specialist shortages, or
- administration's demands on physicians' time.

Work out the money. Funding and budgets details that that will be used to evaluate the program should be clearly specified and reported on a regular

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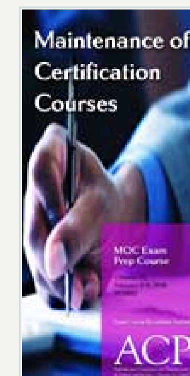

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basis, said Dr. Wachter.

The 2005-2006 SHM Survey: State of the Hospital Medicine Movement reported that 97% of hospital medicine groups received payments, subsidies, income guarantees, services in kind or case rate reimbursement. Operating deficits are virtually always an issue and may cause productivity pressures that lead to unsustainable workloads and physician turnover, said Dr. Wachter. New programs also must account for overhead costs: office space, administrative support, billing systems, training and continuing education.

Set assignments and schedules. The SHM survey indicated that hospitalists are moving away from shift-only and call-only work schedules toward combined shift and call arrangements. John Nelson, MD, a start-up consultant and director of the hospitalist group at Overlake Hospital in Bellevue, Wash., said that there is no ideal scheduling model. Seven-on/seven-off schedules are very popular, but other alternatives may lead to more long-term career satisfaction.

Set productivity expectations. Both Dr. Wachter and Richard Rohr, FACP, director of the hospitalist program at Connecticut's 100-bed Milford Hospital, said that an average workload of 12 to 15 encounters per day is reasonable for a full-time hospitalist. On any given day, though, the actual workload may vary considerably.

Create a shared vision. Use the initial needs analysis to build a shared vision within the hospital and among medical staff, said Russell Holman, ACP Member, chief operating officer of Cogent Healthcare, an inpatient medical management company that starts and operates programs.

Respect established referral patterns. Community physicians are concerned by discontinuity—the failure of hospitalists to communicate to referring physicians and to be sensitive to the referrer's philosophy of care, Dr. Rohr said. Primary care physicians refer to specialists who fulfill patients' needs and they want hospitalists to understand and follow the same approach.

On the other hand, don't get bogged down in mandatory referrals, said Adam Singer, MD, CEO of IPC-The Hospitalist Company, which starts and operates hospital programs. Dr. Singer prefers to build hospitalist programs from the ground up as freestanding group practices by starting with unassigned inpatients and emergency department admissions.

Encourage communication. Meetings promote understanding about the program and gain the cooperation of hospital departments and the medical staff. "We meet with everyone we can—the lab, X-ray, ER, nursing units, medical records and the whole medical staff, especially the formal and informal physician leaders," said Dr. Singer.

Demonstrate medical leadership. The leadership of the hospitalist group is critical. From the outset, the head hospitalist must be able to communicate effectively with the rest of the medical staff and with hospital administration, and must be able to make reasonable decisions in response to the concerns of the various stakeholders.

Show efficiency. Use parameters such as lower costs, shorter patient stays or reduced resource consumption. Patient safety and quality measures are being added to the must-do list, Dr. Wachter said, as are improvements to care coordination or information systems.

Dr. Rohr added that his hospital considers increased admissions, emergency department volumes or contributions to new services. For example, Milford Hospital created a top-notch joint replacement program with hospitalists as key players in comanagement.

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Top

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