

Hospitalist Management Advisor

The pros and cons of geographic rounds

Programs shift to hospitalist-assigned units

In many hospitals, hospitalists are like sojourners, moving to wherever they need to be. On average, hospitalists spend 5% of their day simply walking from one part of the hospital to another without actually doing any work, says **Eric Siegal, MD**, a fellow in critical care medicine at the University of Wisconsin Hospital and Clinics in Madison, who conducted a survey of his 400-bed facility.

In some big hospitals, hospitalists might walk up to four miles per day, Siegal says. To complicate matters, hospitalists rarely have an ideally located office to catch up on paperwork. Often, offices are located at one wing of the hospital or in an area away from patients altogether.

For years, continual walking was considered the best way to conduct hospitalist work. But there are drawbacks, such as inefficiency, taking time away from patients, and failing to build localized teams.

Time-saver

Now, many hospitals have decided the roaming system doesn't work. Some hospitals are electing to use hospitalist-assigned units, giving hospitalists a home base for treating patients.

Known as geographic rounds at larger hospitals, these hospitalist-assigned units can reduce travel time to see patients.

"It can be tough to do your work when you have 18 patients scattered throughout a facility," Siegal says.

If a hospitalist has 12 patients on one wing and six patients on the other wing, the hospitalist will likely see

all the patients in one wing before seeing the other patients. "You end up not treating the patients who need your attention first, but who are closest together," Siegal says. "Obviously, if there's an emergency, you'll see the patient. But that could mean that by seeing one patient later, you don't get to perform a test as early as you'd like."

"General internal medicine is one of the only specialties that doesn't always have a home ... Assigning hospitalists a unit creates a sense of pride."

—Eric Siegal, MD

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The pros: Winning with less walking

Tip: When deciding to make the jump to geographic rounds, consider the benefits you'll see with hospitalist-assigned units. Hospitalists will:

- Cut down on walking time
- Set up a multidisciplinary care system
- Develop better relationships with nurses, case managers, social workers, etc.
- Enhance effectiveness by focusing on change in a smaller area

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Geographic rounds

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- Create a feeling of community that other specialties often enjoy

Geography and teamwork

One benefit of hospitalist-assigned units is the ability to offer more multidisciplinary care, says **Julia S. Wright, MD**, hospital medicine section chief at the University of Wisconsin School of Medicine and Public Health in Madison. This may be the biggest benefit as far as patients are concerned.

“You get your nurses, pharmacists, case managers, social workers, and other clinical staff all working on one

unit along with your hospitalists working as a team,” Wright says.

Medical staff members become familiar with each other and their working styles, allowing for better communication, says Siegal. “Instead of having snippets of conversations before you’re paged, you can do rounds together. Instead of trying to figure out what the therapist did by reading her notes, you can either be there or have a full conversation,” he says.

No place like home

Another reason some hospitals like the hospitalist-assigned units is the sense of investment they feel in a single place and team.

“General internal medicine is one of the only specialties that doesn’t always have a home,” says Siegal. “You’d almost never see cardiology, obstetrics, pediatrics, or neurology without a home base. Assigning hospitalists a unit creates a sense of pride.”

You’ll also gain the trust and respect of the nursing staff members who will see how committed you are to that unit.

“You can function and not have your own unit, but to be able to identify with home base gives them an identity and builds cohesiveness,” Wright says.

The cons: Fighting for space

There are advantages to hospitalist units, but there can be drawbacks too. Hospital real estate is valuable. It’s not always easy to assign a unit to hospitalists; sometimes, it means taking a unit away from another group.

“Every specialty wants its own unit, so you don’t want it to turn into a turf war,” Siegal says. “One of the big drivers for who gets that unit is money, and hospitalists typically don’t bring in the most money.”

Additionally, the battle for space is typically fought between hospital departments and administration, Wright says.

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In hospitals where beds are limited, the administration wants to maximize the throughput of patients, says Siegal. For example, hospital administrators want to make sure an emergency room (ER) patient can be moved to another unit without worrying that the hospitalist unit may be full. To gain administrative support, Siegal suggests the following strategies:

- Get the nursing department and pharmacists behind the plan
- Focus on the benefits of multidisciplinary care
- Be prepared to talk about potential pitfalls, regardless of whether you have all the answers

Not for everybody

Although hospitalists might love the idea of being assigned an area, it doesn't always work according to plan, says **Aaron Gottesman, MD, FACP, CHCQM**, director of hospitalist services and associate director of internal medicine residency at Staten Island (NY) University Hospital.

In 2005, the Staten Island academic hospital attempted several hospitalist-assigned units (e.g., general medicine, crucial care, consultation and inpatient rehabilitation, ER, and geriatrics) in an effort to reap the benefits that other programs enjoyed.

But it wasn't long before Gottesman and other hospitalist leaders realized they were having a tough time maintaining equal distribution of care; some units were consistently busier than others. Even though hospitalists shifted units every two months, that didn't help them handle the patient load.

"There was a lot of frustration that some hospitalists would be free half the day and others would be overloaded with patients," Gottesman says. "But we wanted to keep [the schedule] rigid for the units to work."

Although some of the hospitalists, case managers, and nursing staff members said the geographic rounds allowed for better monitoring of patients, the Staten Island hospitalist program abandoned the hospitalist-assigned units plan in less than two years. Some hospitalists missed walking around and seeing a diverse

patient mix. Some also felt that there was too much of a break in continuity of patient care, as patients were passed between units with changing conditions.

"I can see how it would work well for some hospitals, but I don't see it ever working here, partly because of our academic nature," Gottesman says, adding that trying to balance the program with the needs of the residents made everything that much more complicated.

Initiating innovation

When deciding on implementing hospitalist-assigned units, evaluate the pros and cons. Hospitalists became popular because they were working for the hospital day in and day out, always loyal to the interests of their institution. Hospitals often rely on hospitalists to observe work flow trends, be innovative, and create better procedures.

There can be drawbacks to hospitalists confined to one area, says Siegal. One of the reasons hospitalists have been so influential in hospitalwide changes is because they see patients in all parts of the hospital. By reducing the time hospitalists spend in some locations, you risk losing their institutionwide viewpoint.

That said, hospitalists units often work well at piloting new programs because of their program size relative to the rest of the hospital, says Siegal. "It's easier to standardize an order set or test a theory in a confined group," he says. "New ideas are sometimes destined to fail, and if you keep rolling them out on a hospitalwide basis, people will get tired of the challenges."

Wright has set up a model for piloting new programs and ideas on her hospitalist unit; once something is found to be a success, it is often incorporated into the rest of the hospital, she says.

"The real challenge is not trying to create totally separate units, but trying to find a balance," says Siegal. Determining how to give your hospitalists a home to increase efficiency, build relationships, and feel respected while allowing flexibility in scheduling, patients' needs, and patient flow will determine the success of the program. ■

Case study

Quality improvement is a team sport

How one Maine hospital gains buy-in from the administration

Quality improvement (QI) requires enormous amounts of painstaking work, so much so that QI leaders in small hospitals can be excused for feeling as though their heads are spinning, says **Donald Krause, MD**, medical director of QI at St. Joseph Hospital in Bangor, ME. QI is crucially important and all-encompassing. That's where hospitalists come in.

Hospitalists see every part of the hospital, performing more than 80% of the clinical work. Thus, they are uniquely qualified to identify areas for improvement, particularly patient interaction and process change.

With hospitalists' help, St. Joseph has succeeded in making QI a team priority through what Krause calls a "simple model."

It is a philosophy for an open forum and a support system of personnel dedicated to turn ideas into change and clinical staff members—including nine hospitalists and four midlevel providers—determined to make the hospital more efficient.

QI at one hospital and the nation

Krause helps develop programs through state-run QI initiatives. These initiatives are run through the Maine Quality Forum—an independent group that advocates high-quality healthcare and helps Maine citizens make informed healthcare choices—as well as the Centers for Medicare & Medicaid (CMS) and the Maine Health Management Coalition, a group of large businesses, hospitals, physicians, insurance carriers, and public advocates who study ways to improve care and efficiency in the state.

Like other hospitalists in the United States, the hospitalist group at St. Joseph is engaged in a nationwide effort for quality improvement. Among its initiatives, the St. Joseph group monitors CMS core measures, improves communication among staff members, and tackles patient satisfaction concerns, aiming to reduce

length of stay, improve patient care, and increase hospital revenue.

In 2007, this hospitalist program, with the help of Society of Hospital Medicine, championed an initiative to start a hospitalwide venous thromboembolism prophylaxis program, which is a requirement for patient safety from The Joint Commission (formerly JCAHO).

"[Hospitalists] are a huge piece of what goes on here," Krause says. "They think of everything that has to do with the whole idea of efficiency: the cost of providing the service, how that service is rendered, and how patients flow through that service. Reimbursements are going down, and we are being measured by how efficiently we provide that service and how we perform it."

Simple model makes it look easy: How-to steps

Hospitalists are natural problem solvers, and at St. Joseph, leaders such as Krause have built a simple model for them to contribute to the hospital's QI initiatives:

➤ **Include quality on the agenda for hospitalist group meetings.** Laura Matones, DO, clinical director, chief of medicine, and director of the hospitalist program at St. Joseph, holds monthly meetings with the hospitalist group.

The agenda includes items such as physician communication struggles. Now that Medicare is stressing transparency through its Hospital Consumer Assessment of Healthcare Providers and Systems survey questions for patients, all hospitals must place an emphasis on improving processes.

➤ **Make quality part of every medical service and individual group meeting.** St. Joseph hospitalists are credentialed based on the quality profiles in their medical staff files, says **Stacy Norris, BSN, RN**, director of quality management. These quality items range from administrative data and core measures to service-specific monitoring.

➤ **At least once per year, ask hospitalists what indicators matter most for the care they provide.**

Having hospitalists engage in the development of the indicators makes the process more meaningful and strengthens staff buy-in, says Norris.

➤ **Keep communication lines open at quality committee and department meetings.** At St. Joseph, clinical and QI teams work together.

The medical director of QI meets with the director of the hospitalist program to discuss ideas and offer resource assistance. The QI medical director also meets with the hospital’s director of quality management, sometimes daily, to discuss problems from a medical staff perspective. This model is idea-friendly, Norris says. “It’s an open forum.”

➤ **Write an interdisciplinary project summary with proper sample size.** Krause and Norris provide assistance in adjusting indicators to ensure appropriate sample size and justly reflect practice.

Although St. Joseph generally practices the Plan-Do-Study-Act model, requiring thoughtful planning and due diligence, it has also used a rapid turnaround approach for more immediate needs with tighter deadlines, such as weeks as opposed to months.

If the project involves other departments, the team leader writes an interdisciplinary project summary, and

Krause or Norris present the idea to administration in an effort to gain financial backing for the initiative.

Often, when someone identifies a problem without an obvious solution, the case will be handled by Krause’s quality management department. The team of six discusses problems and brainstorms solutions. “I have a tremendous team, and they do a huge amount of this,” says Krause.

➤ **Pitch QI as a requirement to administrators.** “You have to present your idea in a way that is reasonable,” Krause says.

“It is important in healthcare that quality departments present themselves as cost-sparing departments to attain administration and board support.”
—Stacy Norris, BSN, RN

When a hospitalist or a member of the QI team thoroughly researches an idea, Krause then pitches the idea to administration.

Although winning support for change is difficult with the limited resources of a small hospital, a receptive administration and a good argument can go a long way, he says.

“It is important in healthcare that quality departments present themselves as cost-sparing departments

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Operational data snapshot: Hospitalist X

Month	January	February	March	April	May	June
Discharge time	12:52 p.m.	12:58 p.m.	3:30 p.m.	1:12 p.m.	1:15 p.m.	1:38 p.m.
Volume for discharge	17	26	55	39	34	16
Readmit %	4/28 = 14%	2/36 = 6%	6/66 = 9%	3/58 = 5%	2/45 = 4%	5/36 = 14%
Total preops	0	0	0	0	0	0
Total billed encounters	140	223	301	302	348	68
Average daily census	17	15	18	19	17	23
Admissions	12	25	26	21	28	25
Night float admits	0	32	53	34	0	61
Total discharges	17	25	55	39	26	25

Source: Tools and Strategies for an Effective Hospitalist Program, by Jeffrey R. Dichter, MD, FACP, and Kenneth G. Simone, DO. Published by HCPro, Inc.

Team sport

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to attain administrative and board support," Norris says. If your idea is connected to a requirement (e.g., Joint Commission, CMS, or National Quality Forum), use that angle as a primary selling point. Rules by government regulator agencies carry tremendous weight with administrations.

► **Meet with administrators regularly.** Krause also meets with the chief operating officer once per week to talk about ideas in the pipeline, so he rarely catches the bosses off guard with a proposal.

Buying in to quality: Gaining staff support

It's not easy keeping the QI train moving in a small hospital with ever-growing demands from external agencies such as CMS, Norris says.

"Quality and my other respective departments are not revenue-producing, so budgets are always an issue," she

says. "My administration is very supportive; however, it is tough for all hospitals now to keep up with the demands without adding [full-time equivalents] and/or expanding on technology."

Norris says quality comes down to two components: improvement and assurance. The formula is simple. Each department includes indicators of both in their quality plan.

"If you attain success in both of these, you will improve patient care. If not, you will remain stagnant," Norris says.

Any QI program will flounder if staff members don't jointly engage in the cause.

Ultimately, it's about the people who enact change, Norris says. That's why it's crucial to build support from the ground up, beginning with staff members in the trenches. ■

Consumer-driven healthcare

Experts say quality surveys flawed

The case for redesigning patient satisfaction surveys

With the advent of Hospital Compare and the dawn of user-aggregated Web sites, people aren't simply choosing hospitals and physicians out of convenience anymore. Instead, they're price shopping and researching quality online—organization versus organization and physician versus physician.

In an effort to catch up with consumer-driven healthcare, many hospitals have taken the baton from the government and passed it to contracted vendors such as Press Ganey Associates, Inc., and other companies that compare healthcare facilities.

These agencies conduct patient quality surveys and use the data to design customer service initiatives. But in many cases, hospital administrators also use these data for individual performance reviews and even hospitalist compensation.

Most surveys are not specific enough to gauge the performance of physicians in newer fields such as hospital medicine, according to The Phoenix Group's August white paper, "Hospitalists Meeting the Challenge of Patient Satisfaction."

"These surveys don't accurately show what patients are saying about their doctors. The current methodology is not accurate in terms of a patient's satisfaction with a specific physician," says **Ron Greeno, MD**, cofounder and chief medical officer at Cogent Healthcare in Brentwood, TN, and a founding member of The Phoenix Group.

The search for accuracy

But finding accurate data isn't easy. In fact, it requires fundamentally changing how the government and vendors design surveys to uncover quality information,

Greeno says. The Phoenix Group began as a think tank in 2007 with a mission to provide leadership to thousands of hospitalists in private practices. Today, it acts as a watchdog for healthcare quality and the increasing role of surveys in illuminating that quality.

Unfair comparisons

“More and more, quality and satisfaction will be used to determine payment,” Greeno says.

As of March, the Centers for Medicare & Medicaid Services (CMS) requires hospitals that receive money from Medicare—except for critical access hospitals—to survey patients each year and submit their findings. In turn, CMS will publish those data online. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) on CMS’ Web site are used by all hospitals in compliance with Medicare requirements.

The goal is to collect standard data so consumers can compare hospitals on a local or regional basis, says **Adam Singer, MD**, CEO of IPC The Hospitalist Company, Inc., in North Hollywood, CA, and founding member of The Phoenix Group.

“I believe the industry is still trying to figure out what to do with this data,” Singer says. “It appears that more and more hospital CEOs are going to be incentivized and bonused in some formulaic manner according to how they do on these surveys.”

However, The Phoenix Group found that the HCAHPS is flawed for the following reasons:

➤ **Surveys are tailored for the hospital and not the individual.** The survey questions were designed to compare hospital to hospital, not group to group or physician to physician. The questions are generic, non-physician-specific, and the answers can be misleading.

“They are meant to look at a patient’s overall satisfaction with the experience,” Greeno says. But many hospitals are taking those data and assigning a value to them when measuring hospitalist performance. “It wasn’t designed to do that,” he says.

➤ **Small sample size.** Hospitals are required to survey a certain number of patients, depending on the

hospital size—usually only a few hundred patients per year, Greeno says. This is not a fair population size: Out of all respondents, only one or two may have been cared for by a specific hospitalist, he says.

It’s a case of simple math. “The smallest degree of patient dissatisfaction will lead to a poor score. How is that significant or actionable?” says Singer.

➤ **Misplaced blame.** Another flaw of the HCAHPS survey is that the administration may see a poor score as a reflection of the work performed by an entire hospitalist group.

“In an effort to shift responsibility, hospitals are the ones that are taking the data and focusing on the doctors when they should really be focusing on the entire patient experience,” Singer says. In that scenario, a hospitalist group’s contract may be put at risk because of the survey data. It’s wrong to “blame an entire hospitalist program for a low score, as that group may be managing the bulk of the facility’s inpatients. The doctors are only one part of the patients’ experience,” he says.

➤ **Comparing apples and oranges (hospitalists and primary care physicians [PCP]).** Another area of misunderstanding identified by The Phoenix Group occurs when a hospital measures hospitalist groups against PCPs. For example, a hospitalist may score a 94% satisfaction and a PCP 95%.

“Does it surprise anyone that a patient might be happy to see a familiar face? That is to be expected,” Singer says.

Vendor surveys part of the problem

Hospitals typically contract out to vendors who survey a cross section of the patient population. Those surveys

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Questions? Comments? Ideas?

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Surveys flawed

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generally include HCAHPS questions and the standard patient satisfaction questions the vendor has previously designed, says Singer.

As in the HCAHPS questions, pitfalls appear when using the vendor survey questions to measure quality. The first problem is that the questions haven't evolved with the changing healthcare landscape and are not hospitalist-specific. The second problem with vendor surveys is hospitals scramble to use internal identification systems to discover which hospitalist a patient is complaining about in his or her survey responses. As Greeno notes, hospital administrators are often wrong.

According to internal data from one vendor of patient satisfaction in the white paper, patients weren't coded correctly roughly 20% of the time, misrepresenting whether any hospitalist had been involved in their care.

"But hospitals are still using this inaccurate data," Greeno says, adding that not only can it be inaccurate, it can be misdirecting.

For example, if a hospital looked at patient satisfaction surveys from the hospitalist group versus the cardiology group, the scores would naturally be different. Due to the nature of their role, hospitalists see groups of patients who don't have insurance or a doctor, says Greeno.

"Everyone knows that patients that get admitted to hospitalists are in a population that historically have lower satisfaction scores," he adds. "The surveys are statistically stacked against whoever admits these patients."

Further, The Phoenix Group identified patients' understanding of their case as another challenge related to the surveys. Some older or sicker patients may not be able to distinguish a cardiologist from a surgeon from a hospitalist, Greeno says. Hospitalists can help their cause by keeping their patients better informed about who they are and what their role entails, he says.

At Cogent, hospitalists work with clinical care coordinators to help educate patients about the role of the hospitalist team. For now, the data remain incomplete, and the surveys need redesigning, Greeno says.

Practical tips

In the meantime, hospitalist programs can do the following:

➤ **Seek vendors who want accurate survey results.** The Phoenix Group states that hospitals should first be aware of the flawed methodology used by vendors and shop for vendors whose methodology is demonstrably valid.

"If what the hospital wants is to measure patient satisfaction to the group or the individual hospitalist, then they have to find the vendor who can do that. They shouldn't settle for anything less," Greeno says.

➤ **Pressure your vendor to change.** Remember, you are the vendor's customer and you call the shots. Call your vendor and insist that it consider the hospital's specific needs when tailoring new questions.

"[Vendors] understand the risk in utilizing their surveys in this manner, and I would hope that the company takes steps to curb this activity," Singer says. "I would like to see them demonstrate more leadership in this field and acknowledge that new, more useful survey tools would be helpful."

➤ **Engage hospitalists in the process.** Hospitalists should have a say in the process to improve satisfaction since they are the component of the hospital experience that patients are measuring, adds Singer.

➤ **Advocate for regular committee meetings.** You can also seek suggestions about quality from within the hospital, without vendor input. Meet with staff members at multiple levels throughout the hospital's organizational structure; these types of meetings are not difficult to organize.

"This is the correct venue for these issues, as well as many others, to be vetted, discussed, and plans made and monitored," Singer says.

These meetings will require participation from more than just hospital executives. Ideally, participants will be those on the front lines of improving satisfaction in the clinical and administrative arms of the hospital. ■

An academic hospitalist program

Succeed with protected time

Dedicated extracurricular hours are crucial to efficiency and retention

Hospitalists are clinical physicians by nature. In most hospitals, their primary function is to see patients in an efficient manner while giving them the best care possible. So it shouldn't have been a surprise that when academic hospitals began forming hospitalist programs, hospitalists were initially hired to perform clinical duties.

As academic hospitals began seeing more patients than their residents and house staff members could handle, hospitalists arrived to fill the void in care.

Academic and community physicians are different. Academic physicians are unique in that they are often involved in activities outside of strict patient care, much of which takes place during protected time, or hours allocated by academic hospitals for physicians to take part in nonclinical patient care. But many academic hospitalists aren't receiving the same protected time as their academic coworkers.

"The general principle difference between a community hospital and an academic hospital is the mission," says **Niraj L. Sehgal, MD, MPH**, assistant professor in

the division of hospital medicine and medical director of inpatient services at the University of California, San Francisco (UCSF) at Mt. Zion. "In a nonacademic hospital, the mission is delivering quality patient care, with an emphasis on measuring and doing quality care. Academic hospitals have always been multipronged, with education, research, and quality care always competing. Many academic hospitalist programs are still too focused on just patient care."

Simply filling the clinical void won't lead to long-term success of an academic hospitalist program, he adds. Academic hospitalist programs need to distinguish themselves from hospitalist programs at community hospitals to attract the best physicians and optimize their program.

The catalyst: Resident hour caps

Although hospitalist programs sprouted in hospitals nationwide nearly two decades ago, programs gained

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Academic hospitalist job description

Writing job descriptions for hospitalists at a large academic medical center with residents is different from writing for community hospitals without residents. When creating job descriptions for academic positions, include the following responsibilities:

- Establish primary attending responsibility for inpatient general internal medicine service
- Lead and educate the entire care team
- Work with case managers to ensure proper length of stay, efficient use of resources, and follow-up care
- Meet with families and stay present on the ward
- Supervise residents and medical students
- Conduct teaching rounds and serve as a role model for fellows, residents, and medical students
- Serve as a liaison to referring physicians
- Review all patients with fellows, house staff members, and students, as needed
- Understand, implement, and teach quality and optimum utilization of services
- Develop appropriate inpatient clinical pathways
- Dictate all notes on histories, physicals, progress, procedure, consults, follow-ups, and discharge
- Lead and attend daily review conferences on patients
- Supervise planned discharges
- Ensure proper communication to the primary care physician and specialists

Source: Tools and Strategies for an Effective Hospitalist Program, by Jeffrey R. Dichter, MD, FACP, and Kenneth G. Simone, DO. Published by HCPro, Inc.

Protected time

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popularity at academic hospitals in 2003—the year the Accreditation Council for Graduate Medical Education capped resident work time at 80 hours per week. So although residents formerly provided academic hospitals almost limitless cheap labor, their availability was reduced. Yet the patient load remained the same, and the need for hospitalists arose, says Sehgal.

But instead of hiring hospitalists as they would any other academic physician, with expectations of the physician teaching and performing research, many academic hospitals were focused solely on the overflow of patients when hiring.

That started a trend that makes it tricky to distinguish academic hospitalists from other hospitalists, Sehgal says.

If academic hospitalists aren't involved in education, research, or residents, they are only an academic hospitalist in name and not function, he says. The other responsibilities are what makes a physician academic.

Setting up a protected system

Having academic hospitalists take on the duties (e.g., research, publishing, education, and grants) of other academic physicians has helped their programs thrive, say Sehgal and **Tiffani Panek**, division manager of the

collaborative inpatient medicine services at Johns Hopkins Bayview Medical Center in Baltimore.

Established in 1996, Johns Hopkins' program started with only one physician and a few midlevel providers. But in the past five years, the program has grown from five physicians to 26 physicians. "We also have almost no turnover," says Panek.

Part of the success is the leadership of the program, Panek says, but it's the protected time and opportunities outside of patient care that make it very attractive to general medicine physicians who want to be hospitalists but don't want to solely take care of patients.

All hospitalists at Johns Hopkins start with a 50-hour workweek, with 70% of their time spent on clinical work and 30% in protected time.

Protected time allows physicians to use those hours toward endeavors such as research, leadership, publishing papers, teaching, or committee work. Hospitalists can increase their protected time with grant funding. The system gets the hospitalists involved in many activities.

According to a Society of Hospital Medicine survey, compared to the average academic hospitalist's 10% protected time, UCSF and Johns Hopkins hospitalists average more than 30% protected time. Some hospitalists at UCSF have as much as 85% of their time protected, says Sehgal.

"We're on pretty much every major committee and administration in the hospital," says Panek. "When the chief financial officer or CEO of hospital say there is a problem somewhere in the hospital, we're the first group they come to because they know we can research it and typically find a solution."

Patient distribution solutions

One challenge academic hospitalist programs face is the balance between distributing patients to their hospitalists and their house staff members, including residents. At Johns Hopkins, hospitalists manage patient distribution through a 24/7 triage unit, says Panek.

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The hospitalists determine whether patients who come to the department of medicine for any reason (e.g., admission and transfer) should go to the general medicine department or to a specialty unit.

If patients are appropriate for general medicine, they are separated, with roughly 60% going to the hospitalists and 40% going to the house staff members, as the triage unit makes careful consideration not to overwhelm the house staff members with too many patients at once.

The percentage of patients seen by hospitalists continues to grow. Only three years ago, the house staff members saw 60% of patients. “It’s allowing residents to take on a caseload that helps them learn at a good pace and for the hospital to see more patients,” Panek says.

Opportunity knocks

If academic hospitalist programs continue to hire only for clinical purposes, they might not meet the demand, as the relatively small supply of available hospitalists will likely go to higher-paying community hospitals.

“What drives people to academic settings is opportunity,” says Sehgal.

The opportunity to teach, research, and move up the ladder in nonclinical ways is what attracts top candidates, says Panek, adding that Johns Hopkins rarely has trouble finding applicants, despite offering starting salaries that are \$20,000 less than surrounding community hospitals.

John Hopkins helps its physicians gain that opportunity through its new fellowship program. UCSF similarly offers mentorship programs, faculty development classes, and a curriculum that includes all the skills needed to advance.

Why protected time attracts candidates

Another benefit of academic programs such as those at Johns Hopkins and UCSF is the amount of protected time they offer.

“A lot of other hospitals that are short-staffed will dictate that their hospitalists have to take on more clinical work and cut into their protected time,” says Panek. “If we’re short-staffed, we pay moonlighting money and ask

people whether they want to work. When we say it’s 30% protected time, we mean it, even if it means it’s tough to make the schedule every month.”

Hospitals should treat academic hospitalists just as they would an academic cardiologist, says Sehgal. “They should have the same expectations for promotion and success and should be given the same opportunities,” he says.

That promotion is typically dependent on work completed during protected time, Panek says. Whether it’s publishing papers or getting grants—both of which bring hospitals attention—academic hospitalists should be held to high expectations since their services don’t typically bring the hospital as much reimbursement as other specialties. Attention isn’t typically the goal of a hospitalist program, but being innovative and earning a reputation as a notable program might be.

“If you’re only expecting your hospitalists to be clinical and match the responsibilities of those in a nonacademic institution, you’re selling your program short,” Panek says. “We always say, ‘Have one pie-in-the-sky goal,’ where you’re willing to take risks and challenge yourself.” ■

Illustration by
David Harbaugh



“I don’t need a résumé. I’m complex, highly motivated, decisive, resourceful, dynamic, something of a visionary, and I provide moral and ethical leadership. At least, those are the qualities I’m aware of.”



Recruiting tip of the month

Identify your strengths for a competitive candidate

After one Southeast hospital closed, a neighboring primary care group with 200 physicians suddenly found itself coping with an overwhelming patient load, and it had to quickly relieve the strain on its hospitalists.

In the past, this primary care group handled its recruitment successfully and enjoyed a low turnover rate. But the neighboring closure made its hiring task too large for the group to tackle internally.

Time was short; it would need to hire approximately 10–12 new hospitalists in six months. For this reason, the primary care group engaged Cejka Search to implement a national strategy.

Strategy

Cejka Search introduced on-site consultants to survey and assess the group's needs.

Although the primary care group successfully recruited for retention with previous hires, it still needed to make the hiring process more efficient. In addition, the candidate pool was small, creating yet another difficult challenge.

Cejka Search chose to showcase the group's strengths to attract more candidates.

The group had plenty to offer—higher compensation packages and signing bonuses and an extremely low turnover rate—yet the group had not touted those advantages to potential candidates.

To make the positions even more competitive, based on the team's recommendation, the primary care group offered a loan repayment program for hires—an uncommon strategy in this part of the country.

Cejka Search also suggested highlighting the community's dynamics and exceptional educational system, positioning the group's location as an advantage.

It was essential for the group to examine the candidates' needs to make sure that there was a cultural fit outside of the office.

Results

With these strategies, the primary care group achieved great success within five months.

With Cejka Search's assistance, the group hired eight new hospitalists.

It is important to keep the candidate in mind when promoting your practice's attributes, such as community location, which might generate interest. What some might consider a weakness can be positioned as a strength for a targeted pool of candidates. ■

Editor's note: This month's recruitment strategy was submitted by Germaine Lorbert, senior search consultant at Cejka Search.

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—Karen M. Cheung
Associate Editor

Dear valued subscriber,

HCPro, Inc., has made the difficult decision to stop publishing **Hospitalist Management Advisor (HMA)**. The November issue will be the last issue of this newsletter.

However, you will continue to receive the hospitalist management information you need to run an effective program. **HMA** subscribers will now receive **Medical Staff Briefing (MSB)**, which includes **Hospitalist Leadership Advisor (HLA)**—a comprehensive 4-page insert devoted to hospitalist management topics.

MSB has an 18-year history of providing medical staff leaders with strategies to measure and improve physician competence, conduct effective peer review, manage physician performance, and ensure compliance with Joint Commission standards. **MSB** and **HLA** will provide medical staff members and hospitalist leaders with tools to implement successful recruitment and retention strategies, align and achieve hospital and hospitalist program goals, and manage a hospitalist program that improves quality of care while also improving the bottom line.

We appreciate your loyalty to **HMA** over the life of your subscription and hope you find your new subscription to **MSB** to be a valuable tool. If I can be of any assistance to you during this transition period, please feel free to contact me. Thank you again.

Sincerely,

Karen M. Cheung



Associate Editor, **HMA**

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