

6 Questions ...with Adam Singer, MD

If anyone understands the state of US hospitals and the role of the hospitalist, it's Adam Singer, MD. He is Chairman and Chief Executive Officer of IPC: The Hospitalist Company (www.hospitalist.com), which he founded in 1995, and was named Modern Physician's "Physician Entrepreneur of the Year" in October 2008. Singer is also one of the organizers of the Phoenix Group, a "think tank" of physicians and hospital medicine experts who regularly meet to discuss the issues facing hospital medicine. The Phoenix Group recently released three white papers that address the challenges of the hospitalist workforce shortage, ensuring patient satisfaction, and securing the future of private practice hospital medicine (www.thephoenixgroupwhitepaper.com).



1 "Improving physician productivity with cutting-edge technology" is one of the solutions proposed by IPC. Do you have specific examples in mind?

We use electronic charge capture methodology that is combined with IPC-Link, our proprietary clinical communications

technology. There are two main requirements of every hospitalist in terms of their workday. They have to communicate to their outpatient partner (primary care physician) who is no longer in the hospital, and at the same time, be able to generate charge capture. By using IPC-Link, they accomplish both tasks at the same time and are able to capture more charges. So, there's less charge capture work for the physician, which actually creates a productivity improvement. Plus, you're able to communicate with the primary care physician at the same time. It's the combination of charge capture and clinical communications that improves productivity. You have in one place all of the data that physicians need in order to measure and monitor their own performance. That can enhance their productivity by allowing them to know who is seeing which patients

and who's not busy or who's too busy. It can monitor the acuity of care of the patients so that there's a better division of patients within the team. And it can track length of stay, readmission rates, medication use by diagnosis, etc. Having access to all of this data in real time empowers physicians to make better choices and allows for better division of labor within the team.

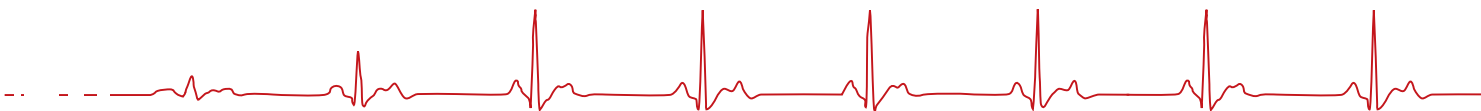
2 What prevents physicians from focusing on delivering care?

In the hospitalist world—a very young specialty, particularly in smaller groups—they have no true infrastructure. We have a centralized infrastructure here in North Hollywood—things like risk management, healthcare services, the medical affairs team, recruiting team, the finance office, the billing office—all of these resources that, if physicians just send their clinical note and do their charge capture using our technology, we're able to communicate back and forth with that physician in real time. The physician is getting all the support needed just by using this technology to do his or her job and therefore can really just focus on patient care. They don't have to worry whether someone is

watching their back on risk; that their bills are being sent out in clean claims; or that we're seeing that the volume of business is growing and that we need to start recruiting more physicians.



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3 How is the economic downturn affecting hospitals and hospital medicine? What signs will indicate that the situation is worsening or improving?

I think hospitals are cutting back on support for hospitalists, especially those groups that are inefficiently run, that aren't doing aggressive charge capture and collecting the money for the work they are doing. You are going to see groups start to fail. I think you are going to start to see hospitals that employed their own hospitalists outsourcing them or letting their physicians go because they can't afford them anymore. I think that you're not going to see hospitals forming hospitalist programs, again because those programs are heavily subsidized and the hospitals can't afford it. They can't access credit, and therefore, are tightening their belts. I think another warning is that you see hospitals laying off nursing staff and ancillary staff, again to cut costs. I think that hospitals are in deep trouble. I think on the hospitalist side, you are seeing similar problems. They can't hire more doctors because they can't afford to carry those doctors until they start collecting for them. You're seeing hospitals that can't grow because they can't access credit.

4 If one of the solutions to address the hospitalist shortage is to tap the pool of family practitioners, to what extent is that just robbing Peter to pay Paul? What effect will that have on hospital medicine?

Well, I think that we have a tremendous problem brewing—there are not enough primary care physicians to meet the demand for hospitalists and to man the outpatient sector. There used to be 110,000 internists, and now there are 28,000 hospitalists; so, you have 28,000 fewer outpatient providers, making for a shortage on both sides of the equation. We don't have enough hospitalists yet; we need 40,000, and yet we just took 28,000 people out of the outpatient office. It's not really one for one, though; the productivity of those outpatient doctors improves as they no longer go to the hospital. So it's not like you lost one outpatient doctor and now you're 1% less out there. It's all relative, because their productivity

can increase. But, indeed, it is a problem that there are not enough primary care physicians, and we are seeing shortages on both sides right now, both inpatient and outpatient.

5 How can the profession start bridging the gap?

Well, there's a realistic answer, and then there's the dream. The realistic answer is that we are going to have to use more ancillary providers like NPs and PAs, both outpatient—which has already happened in large part—and for hospitalists. There just isn't anybody else to do the work. The dream—and I say “the dream” because it's 20 years away from ever being realized if we start today—is that we need to increase the number of medical school slots in general in this country, because we're not producing enough physicians. What used to happen to backstop the system is that foreign medical grads would be used because there are more residency slots than there are US medical graduates. The problem is that a lot of these doctors are coming from other countries, training here, and now electing to go back to their home countries. And that's because of huge restrictions on staying in the US, with more difficult visa requirements for example, as well as the economy in general. One of the things that maybe midterm we need to do is relax some of the J1 and H1B visa requirements to allow foreign school physicians to stay in this country.

The only other alternative is to increase medical school slots, and that's going to take at least 10 years. With millions of baby boomers hitting the Medicare ranks and a system that's in tremendous shortage today, where are the providers going to come from?

6 Are you in favor of universal health coverage, and if so, how do you define that term?

Universal health coverage to me means that each person has some form of payment mechanism for the care they are going to receive—that they are insured. I am certainly in favor of that. People should not be in a position in which they cannot access care because there's no way to pay for it. The challenge you're going to have, and I don't see a solution, is that you are replacing this universal coverage problem with a universal access problem. Once you insure everybody, you still have a problem: who is going to take care of them? If you add 40 million uninsured to the ranks of people who are now going to access care, there are no providers to care for those 40 million people. I believe you are still going to have a problem in which the providers are going to tier and say “well, I'll take the better insured patients then.” And the universally covered patients, who will have some lesser form of insurance, are still going to have trouble getting care, because they won't have access to care, kind of like Medicaid patients do today in many states. I think that the universal coverage issue is only one part of the problem—you have to think about access at the same time. You can't solve it unless you find more providers. *mdmg*

