

Hospitalist Management Advisor

The next evolution of hospitalist programs

Keep your program and physicians viable amidst rapid growth

In 1998, there were approximately 2,000 hospitalists employed in North American hospitals. The Society of Hospital Medicine says that number has grown tenfold in just 10 years and will reach about 30,000 by 2010.

The profession is growing exponentially, and the role of hospitalists in many organizations is expanding in concert with that growth.

To further establish the importance of hospital medicine and advance the profession, hospitalists must continue to pave inroads within their respective organizations, in both direct care and nondirect care endeavors, says **Eric Siegal, MD**, regional medical director of Cogent Healthcare in Brentwood, TN.

“There are clearly avenues that hospitalists have taken and should continue to take, and hospitals should be investing in this growth,” he says.

Maximizing clinical value

Professionally, hospitalists have begun to branch out. Many are now more involved in cosurgical and cospecialty management, and many have established a presence in peri-operative and palliative care.

“Those are two clinical niches that hospitalists have filled and will continue to fill,”

“Hospitals are looking for physician champions. And hospitalists will be on the very short list of physicians asked to do this.”

—Eric Siegal, MD

Siegal says, adding that geriatric care and acute diabetic management are two other areas that have seen growth.

More specifically, hospitalists—as full-time, hospital-employed physicians—have the opportunity to affect significant change within their organizations by tackling longstanding clinical challenges, says **Susan Wisniewski, MD**, associate director of the hospitalist group at Staten Island (NY) University Hospital (SIUH).

Wisniewski, who has worked with her hospitalist group for more than five years, suggested the following specific areas of focus for hospitalists:

- Decreasing length of stay
- Decreasing utilization of resources/cost per case
- Improving quality of care
- Improving diagnosis-specific outcomes
- Reporting on quality initiatives

“These are all completely measurable variables and can be used to provide hospitalists with feedback data leading to motivation for improved performance,” says Wisniewski, adding that work in such focus areas could also provide the basis for determining eligibility for incentive bonuses. But program managers and hospitalists should brainstorm other potential areas of focus to



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Your hospitalist program generates data that can showcase your program's value—but only if you know how to grab it.

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maximize physician value. For example, Wisniewski found that her program could utilize hospitalists to handle certain billing problems. The junior hospitalists, fresh out of residency, had no practical experience with appropriate billing processes, Wisniewski says, so the hospitalist program implemented an educational program with real-time feedback from a professional coder.

The coder reviewed bills submitted by individual hospitalists and compared them to the coder's documentation of the service the physician rendered.

"We discovered that most hospitalists were under-billing, which was obviously a potential source of lost revenue, not to mention a potential compliance issue," Wisniewski says.

The billing process is much more efficient now, and hospitalists are maximizing their financial value to the organization.

The program at SIUH discovered that its hospitalists spent a significant amount of time participating in activities for which they did not bill—for example, the organization's rapid response team.

However, after further investigation, program leaders learned that this participation was actually a billable service.

"Now we have discovered that not only does our participation in the rapid response team have a direct impact on the quality of patient care, but it is a valuable resource for us to maximize billing opportunities for real services rendered," Wisniewski says.

Another focus area that may improve clinical efficiency in lieu of expanding the hospitalist's role is niche care, or specializing in certain types of procedures.

"The idea is creating a dedicated hospitalist that does all of these certain procedures, and that would likely result in lower complications," Siegal says.

Although one of the allures of hospital medicine is clinical diversity, Siegal doesn't believe the practice of niche care would be unappealing to physicians.

"I think there's enough variation within hospital medicine that people will remain interested," he says. "If you do palliative care, you're not necessarily niching yourself, so that is one example."

Nondirect care growth opportunities

Many hospitalists are interested in the balance between nondirect and direct care. This is a tremendous opportunity to grow professionally, become a recognized leader in the hospital, and improve the quality of not only the hospitalist program, but the organization as well.

"Hospitals are looking for physician champions," Siegal says. "And hospitalists will be on the very short list of physicians asked to do this."

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Some hospitalists are passionate about quality improvement methodology; others may enjoy the regulatory components of their work.

As hospitals move toward paperless systems, there is a greater need for physician advocates. And hospital administration should be another target for hospitalists.

"The hospitalist of today is the [chief medical officer] in 10 years," says Siegal. "Who better understands the hospital than the hospitalist?"

Hospital administrations have begun to invest in and promote physician leadership and understand that the kind of adversarial relationship with the medical staff that was common in the 1980s and 1990s isn't good for business, says Siegal. "You see [hospitals] investing more in physician training," he says. "Hospitals know they have to invest in at least potential leadership."

The commitment and initiative a hospitalist needs to advance further into the hospital infrastructure can be hard to find.

But the roads to travel are marked clearly, says Wisniewski. Academic activities and committee participation are among the keys to success, she adds.

At SIUH, hospitalists have many opportunities to participate in various academic opportunities, both at the medical student and resident levels.

These opportunities include:

- Medical student lectures
- Bedside exams
- Mentorships
- Preceptorships
- Resident morning reports
- The journal club

"Participation in these activities is mostly on an individual, voluntary basis; however, there are some minimal requirements on a departmental level," says Wisniewski.

Committee participation is just as easy for hospitalists to take part in at SIUH. Wisniewski says such opportunities depend on the individual's personal interests and can range from the resident research

committee to the ER committee to the rapid response team committee.

How to climb the ladder

The individual hospitalist must be proactive, Wisniewski says. The hospitalists should express his or her own personal interests to the appropriate leaders, both on the group and departmental level, and enlist their support.

"He or she must be engaged," she says. "He or she must become involved in taking on additional responsibility, knowing it may lead to future opportunities within the group or department."

The program leader should recognize involvement in these interests, as it will foster growth and reward ambition, says Wisniewski. A specific strategy is to offer financial recognition through competitive salaries, appropriate salary increments, and incentive bonuses, she says.

"The hospital also has an obligation to allocate appropriate resources to its hospitalist program, including staffing and funding for ongoing education, such as [continuing medical education] reimbursement," she adds.

The hospitalist leader must be an advocate for hospitalists in this respect, Wisniewski says. Administration must understand how important the advancement of hospitalists is for the financial well-being of the organization.

Direct care endeavors lead to decreased costs for the institution, improved quality of care, greater patient satisfaction, and consistent compliance. But the benefits aren't limited to the clinical side of the job.

"I personally feel the organizational benefits are astronomical involving nondirect patient care," Wisniewski says. "They transform the hospitalist into an integral member of the team and [an] integral member of the institution as a whole. The hospitals can now be the key factor to integrating quality patient care with the education of the house staff, thus making the hospitalist an invaluable asset both now and even more so in the future." ■

Illustrating value

Steps to define your hospitalist program's contribution

The hospitalist program is the clinical staff's exciting new toy—fresh, inventive, and promising. But from the C-suite point of view, administrators may consider the program costly and unproven.

That means experienced and inexperienced hospitalist leaders alike face the challenge of proving their program's worth to an administration that isn't necessarily informed of the work staff members do in the hospital.

But according to hospitalist experts, there are both hard and soft data to tap into that can illustrate the importance of the hospitalist program to the organization. The key is determining what information to pull and how to present it.

"It's important to understand that accurately collected data don't lie; it's the interpretation that can be misleading," says **Aaron Gottesman, MD, FACP, CHCQM**, director of hospitalist services at Staten Island (NY) University Hospital.

More importantly, these data are necessary to keep your program financially afloat, says **Ronald Greeno, MD**, chief medical officer at Cogent Healthcare, based in Irvine, CA.

"Hospitals are investing significant dollars, so you have to financially justify what the program brings to the hospital," Greeno says. "That means putting numbers around it."

Data and metrics

Every hospitalist program produces hard, relevant data. But first you must define the metrics by which your organization will judge the program. "There needs to be an agreement between all stakeholders," says Gottesman.

That consensus requires those stakeholders—i.e., the CEO, the chief operating officer, the chief financial officer (CFO), the vice president of finance, etc.—to commit to the time it will take to develop a plan, and that will likely require several initial meetings, says Gottesman.

"It's very difficult to agree upon and achieve consensus unless everyone has done their research," he says.

Program leadership should research a comparable program in size and scope to model. If possible, leadership should search for regional or local models, as opposed to national ones, says Gottesman.

There can be many significant differences among programs that may, on the surface, look like similarities, such as the percent of insured vs. uninsured patients.

"Rigid numbers are not comparable across the board," Gottesman says. "But the basis of comparison must be consistent."

Quantifying value

Greeno says a process of quantifying value is the most effective way to tell your story. Quantifying value allows a hospital to:

- Understand to what extent it can invest in the program
- Recognize the role the program can play in its overall strategic planning
- Use existing infrastructure to maximize program performance

Conversely, it allows a hospitalist leader to:

- Emphasize the facets of the program that create the most value
- Create aligned incentives for the hospitalist team
- Justify compensation necessary to hire physicians in a fiercely competitive environment

Cost reduction

The three categories of value creation are cost reduction, revenue generation, and cost avoidance, says Greeno.

Cost reduction is the easiest to calculate, as it requires accurate, severity-adjusted hospital data. For example, look at the cost reduction your organization

achieves by using hospitalists to treat specific cases, as opposed to not using hospitalists. Take that reduction and multiply it by the number of those specific cases your hospitalists handle in a given time frame, and you'll have hard financial data that support the work of the hospitalist team.

Another example you can look at is drug costs. Specifically, determine how much lower the average number of medications was per patient when using hospitalists, as well as the length of IV therapy and gastrointestinal medications. The cost savings will give your program another way to put a number on the work of the hospitalist team.

Revenue generation

Revenue generation is more difficult to sell because it usually involves softer evidence. Still, the information can be convincing, and it's important to consider these data when making your case.

"The hospitalist movement is here to stay," Gottesman says. "We need to optimize the hospitalists as faculty within the institution and work on the return on investment, though not always in dollar terms."

Revenue generation could include the following, says Greeno:

- Increased inpatient bed capacity
- Improved patient throughput and ER diversions
- Improved market share

- Improved satisfaction of patients and community physicians
- Appropriate documentation
- Quality measures and pay-for-performance initiatives

If you can demonstrate that your hospitalist program keeps your hospital's ER from diverting patients, you can make a strong case for your program, Greeno says.

Not only are you moving patients in and out of the ER and fostering strong patient satisfaction, you're not turning away your paying customers. When your hospital is full, it must still treat the emergent cases, but it often must turn away the elective cases. That's the group of patients that can make a notable, positive financial impact.

"So if you're not on diversion, and you're accepting these cases, you're markedly increasing the ability to admit the patient you want to admit and need to admit to be financially successful," says Greeno.

Your CFO might argue that this scenario only makes a financial difference if you can fill that hospital bed. But Greeno says that even if you cannot, "you now require less nursing support."

Additional cost-saving avenues to explore should include screening inappropriate admissions. Payers often deny payment when a case does not meet the criteria for admission, and hospitalists have become more involved in that decision, says Greeno.

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Simple steps

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Coding is likely another financial challenge for your organization. “If you can teach one hospitalist how to document correctly, it allows the hospital to do a much better job of billing for the services,” Greeno says. “You would then have a much easier time showing that reimbursement goes up.”

Another revenue generator is your hospital’s ability to attract primary care physicians to conduct testing. Use your success in this area to advertise the program as a hospital service line and get a competitive advantage in your market, says Greeno.

Cost avoidance

Investing in your hospitalist program may decrease readmission rates of your uninsured patients, resulting in savings for unpaid care. Greeno cites an example of a hospital that initiated a discharge plan and saved \$4.5 million in three years.

You may realize another cost avoidance in staff retention. “Nursing turnover is a tremendous cost to hospitals,” says Greeno; it may cost an organization more than \$50,000 when it loses a nurse.

Staff satisfaction

That said, staff satisfaction should be one of the administration’s top priorities. For the most part, clinical staff members appreciate and depend on the work of the hospitalist teams within their organizations.

So finding clinical support should be easy. To gauge the appreciation, Gottesman sometimes jokingly tells someone on the case management team that the hospitalist program is leaving the hospital to see his or her reaction to the news.

“The look on [his or her] face is like they’re having an MI right there on the spot,” he says. “The hospitalists have become so indispensable that it’s like saying that we’re going to shatter the foundation of the institution.”

It might be useful to align other members of the leadership team, such as nursing, case management, the emergency department, and other clinical realms, to write letters of support for the hospitalist program, says Gottesman—“not generic letters with platitudes, but letters to define effectively how having a hospitalist program has helped their ability to function, and how not having the program would have dire consequences, and defining those consequences.”

One long-term strategy should be to integrate hospitalists into all areas of the institution, such as having them participate in projects and on committees, so they become more visible to the C-suite.

“It’s important to have individuals who are experts, physicians being the drivers of quality,” says Gottesman. “Hospitalists are showing their ability to champion patient safety. That shows tremendous value [in the program].” ■

Case study

Increase quality by tweaking existing practices, relationships

When the Michigan Quality Improvement Organization (QIO) asked hospitals across the state to examine their one-day admissions, Borgess Medical Center in Kalamazoo, realized that there had to be a way to reduce the number of one-day inpatient stays and ensure, when they did happen, that they were medically necessary.

Because the project focused on Medicare patients, the 426-bed hospital turned to the hospitalist program to examine the hospital’s existing practices and determine what improvements could be made in the future. “Hospitalists attend to greater than 75% of the Medicare population in the hospital,” says **Marilyn Barnum, RN,**

utilization management coordinator at Borgess Medical Center. “Instead of dealing with 300 independent physicians, we wanted to be more focused. We felt we would get the most bang for our buck working with hospitalists, a team of about 25 staff members.”

Identifying the root problem

The focus of the hospital’s study was to determine ways to make sure every patient admitted for inpatient care had a medically necessary need. For longer stays, this normally wasn’t a problem. But for patients only staying one day, it was sometimes difficult to justify the need for the admission, says Barnum.

The hospital organized a team to look at the issue. In addition to Barnum, the team comprised the director of quality, the chief physician officer, a hospitalist, a nurse from admitting, and one care manager from the ER and from cardiology.

“After just a brief investigation, we traced [the issue] back to the physicians not being clear about a patient’s status on their orders,” Barnum says. “Physicians notoriously don’t think observation versus admission. They think it’s just a financial difference and don’t state what they actually want.”

Physicians who subscribe to that notion are right about the financial aspect—hospitals do get reimbursed more for an admission than an observation, which is precisely why the Centers for Medicare & Medicaid Services and QIOs see it as such a problem.

Devising a simple solution

The team talked to physicians and case managers in the hospitalist department to determine how to develop a system that would force physicians to state specifically when they wanted a patient admitted and why. What they came up with was a simple addition to their clinical pathways protocol.

They created check boxes at the top of treatment and order forms that clearly prompt the physician to document the patient’s intended status. (See p. 8 for a sample of the form.)

“Without much training, the forms almost immediately improved our one-day stay documentation of medical necessity,” Barnum says. “Our records began showing clear [status documentation] from physicians.”

With similar check boxes on all generic order forms, physicians quickly became accustomed to the process, and there were no complaints about added time or paperwork.

Reinforcing partnerships

Another idea the team devised was to closely involve care managers with patients admitted in the ER. “Care managers partnering with our hospitalists proved to be a great success,” says Barnum.

This plan included training; specifically, hospital-held sessions led by the chief medical officer that gave care managers the strategies they needed to obtain the hospitalists’ attention and support. To meet this increased need for care managers, the hospital extended its care manager coverage to seven days per week with 12-hour days.

Because care managers were often the first in line to view physician orders, they were given the task of checking hospitalist documentation to verify that there was a clear order, and the hospitalist documented the medical necessity for whichever status they chose, says Barnum. This resulted in a lot of one-on-one conversations in which the care managers asked the hospitalists questions, such as:

- What was your plan?
- What was your thinking when you said you wanted an admission versus an observation?
- Could all of these tests be accomplished in less than 24 hours?

“We just were trying to pull out what the physician was trying to accomplish for the patient,” Barnum says. “By improving communication between the care manager and the hospitalist, we saw a direct impact on patients not being admitted and instead being appropriately transferred to the next level of care, such as a nursing home or a visiting nurse.” ■

Case study

Creative solutions and familiar faces boost hospitalist program launch—and keep it running

In rural communities, hiring qualified physicians can be a difficult task for hospitals. But hospital staffing issues in less populated parts of the country don't affect just the hospital—they affect all healthcare providers in the area.

When Harris Regional Hospital in Sylva, NC, an 86-bed acute care facility located in the mountains and 35 minutes from the next closest hospital, experienced recruiting problems for the first time a few years ago, the administration knew they had to make a change.

“Our medical staff had always remained satisfied, but we were running into more and more physicians who said, ‘We’d love to come work for the system; it’s a beautiful area. But we don’t want to work hospital hours,’ ” says **Luanna Easton**, vice president of performance management at WestCare Health System, Harris Regional’s parent company. “We realized starting a hospitalist program was the only way to keep the hospital fully staffed with physicians and to keep other physicians in the system happy that they could work nine to five on weekdays.”

Recruiting a familiar face

When the idea to start a hospitalist program first surfaced, Easton says administrators considered bringing in outside vendors with ready-made practices. But after some initial conversations, the hospital recognized that in such a tight-knit community, its patients wanted to know their physicians and wanted them to be people they could trust.

So the hospital turned to one physician that everyone in the area knew and trusted from his years of experience at the hospital, Robert “Bob” Adams, MD. Adams had been with the hospital since 1976 and was willing to do whatever it took to see the hospital thrive.

“If we were going to start a system like this that changed the way patients used the hospital, we knew

we needed a physician who patients would recognize,” Easton says. “People around here don’t always like change, and it would be a change for them to come to the hospital and not be seen by their regular physician. There isn’t a person around here who doesn’t know Dr. Adams and his enthusiasm for taking care of his patients.”

Adams had a reputation as the physician who worked extra hours and covered for outpatient physicians who couldn’t make it in to see one of their patients. In other words, he was already a hospitalist in spirit, just not in name.

Improvising the plan

The initial plan was that the hospitalist program would have five or six other private practice physicians in addition to Adams, but as the date of the program launch approached, those other physicians started backing out, Easton says.

“Once the ball had been put in motion to start the hospitalist program, it needed to continue,” she says. “Our [medical] staff team said they were too overworked and needed the help.”

So Adams and the administrators decided that the only way to make the program work would be to use nurse practitioners (NP) to supplement the program and work alongside Adams. (See the sample job description on p. 11.)

“Dr. Adams said he could take responsibility for all the patients, but there was no way he could do all the paperwork, all the rounds, and all the discharges,” Easton says.

Making it work

A process that began in early 2006 went into action in August 2007. In addition to Adams, the hospital hired

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Creative solutions < continued from p. 9

two NPs for the program, and eventually found one internist. The hospitalist program was in effect, ready to tend to approximately 60 patients per day.

“The hardest thing to get used to was the flow of patients,” Easton says. “Dr. Adams had initially hoped he’d still be able to keep some of his primary care duties, but that quickly became impossible.”

That issue aside, the program is not only working, it’s thriving, says Easton.

“Our patients are fairly spoiled because they are used to going into the office and having a physician there waiting for them,” she says. “Now, instead, the NPs are there starting the admitting process and easing the patients’ fears. It worked better than we could have imagined, but we were helped out by the fact that the NPs were local, knew some of the patients themselves, and were also very well trained.”

The partnership among Adams, the internist, and the two NPs also came together nicely. However, the hospital’s ultimate staffing goal for the hospitalist program is to employ six physicians and three NPs, says Easton.

“Dr. Adams knows he can’t be at every patient’s bedside all the time and on admission, so it’s great he has NPs he can rely on to do chart audits, gather medication lists, etc.,” she says. “The NPs really shield our two physician hospitalists from a lot of the side stuff so they can focus on patient care.”

Capitalizing on success

Setting up a working hospitalist program that quickly in a rural community might not work in every hospital, especially those in larger systems. But Easton says for hospitals like Harris Regional, it can be done if you get the right people involved. “I think we’d all love to have a group of physicians out there saying, ‘Let us in, we want to be hospitalists.’ But from a financial standpoint, when you can’t find physicians to fill the roles, NPs are great assets.”

The hospitalist program may not be one of the highest profit areas of the system, Easton says, but it has been a stabilizing force that has allowed Harris Regional to retain its physicians while filling a void in the care process.

Developing and maximizing your hospitalist program

As hospitalist programs take root in more and more healthcare facilities, you must prepare for your program’s future and seek ways to make it both effective and competitive.

The **Hospitalist Management Advisor** and The Greeley Company seminar “Developing and Maximizing your Hospitalist Program” will help you learn how to:

- Gain access to the tools your colleagues are using to carry out their leadership responsibilities in running a hospitalist program
- Improve job satisfaction and retention by understanding the importance of the link between hospitalists and allied health professionals/case managers/mid-level providers

- Better define the roles of hospitalists to improve communication with primary care physicians and specialists, and to facilitate handoffs
- Develop ways to align hospital incentives with those of hospitalists
- Avoid burnout among hospitalists and improve the quality of work-life for MDs/DOs on your team through scheduling, culture, etc.

Join **HMA** and The Greeley Company September 25–26 for “Developing and Maximizing your Hospitalist Program” at The Hyatt Regency in Chicago.

Visit www.greeley.com and click the Seminars tab (listed by seminar date) to register or learn more.

Easton gives much of the credit to Adams and his staff, but said the effort the hospital made to inform the public of its new hospitalist program and what it meant for them as patients made a big difference as well. Physicians' offices provided fliers and information pamphlets

about the changes that explained what a hospitalist program is and why the system decided to use one.

Most patients have adapted quickly, although Easton notes that some of their older patients still aren't keen

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Sample hospitalist nurse practitioner job description

Editor's note: For hospitals looking to add nurse practitioners (NP) to their hospitalist programs, consider the following as a basis for the job description.

Position: Hospitalist NP

Reporting relationship: Program medical director/program manager

Position summary: The hospitalist NP provides high-quality and cost-effective medical management of patients under the care of the hospitalist program as privileged by the hospital and within its stated scope of practice. The hospitalist NP collaborates with the hospitalist care team to coordinate and manage the process of patient care from the point of admission to the hospital through discharge and handoff to a community care provider.

Essential functions

Medical management

- Identifies and manages acute illness from admission through discharge with adherence to best practice guidelines
- Performs histories and physicals and creates plans of care for patients admitted to the hospitalist service
- Communicates with hospital staff members to ensure timely implementation of patient care plans
- Communicates and coordinates with patients' primary care physician for continuity of care and appropriate follow-up care, including preparation of the discharge summary and the transfer of care note
- Communicates with hospital discharge planning to ensure an appropriate and safe discharge plan and disposition
- Resolves postdischarge homecoming call issues as needed

- Prescribes medications and therapies as appropriate
- Collaborates with the team hospitalist as needed to assure safe and effective patient care

Quality improvement

- Provides clinical care with appropriate utilization of resources based on current standards/national guidelines, utilizing decision support tools such as Interqual Criteria
- Participates in care team and client meetings to assist in evaluation and development plans for the hospitalist program

Education/public relations

- Educates patients and families about the role of hospitalists and NPs in hospital medicine
- Educates patients and families regarding the plan of care
- Educates and promotes the hospitalist program among hospital staff members

Qualifications

The hospitalist NP should have the following qualifications:

- A degree from an accredited school of nursing with MSN, DNP, or DrNP
- An NP license in his or her practice state
- Certification in acute care or as an adult NP; consideration of family practice and geriatric certification with recent acute care experience
- Ability to work as a team member
- Excellent analytical and problem-solving skills
- Excellent written and verbal communication skills
- Fundamental knowledge of PC-based applications

Source: Cogent Healthcare, Irvine, CA. Adapted with permission.

Creative solutions < continued from p. 11

on not seeing their regular physicians in the hospital. But she says she expects that trust to build up more over time.

The NPs have also been satisfied with the program because it allows them to see a much wider variety of patients than they'd see in a private practice, giving them invaluable experience and more interesting days, Easton says.

Since starting the hospitalist program a few months ago, Harris Regional and WestCare Health System have already started seeing a change in their recruiting and hiring, says Easton.

"We're seeing higher physician satisfaction and having an easier time convincing physicians this is a good situation to work in," she says. ■

Survey

Hospitalist expansion seen as critical to organizations' recruitment and retention strategies

To gain insight about trends in the recruitment and retention of physicians, Cejka Search and the American Medical Group Association (AMGA) have gathered data from medical groups that reflect turnover statistics among a population of 13,000–16,000 physicians each year since 2005. The medical groups employing these physicians have shared their insights in the areas of mentoring, setting clear expectations, offering sabbaticals, and developing new clinical models—all of which respondents have identified as effective retention strategies.

The evolving clinical model

The survey results have identified the expanding use of hospitalists as an important element in medical groups' efforts to recruit and retain physicians.

Survey respondents said the following:

- "We are actively recruiting hospitalists. We see a viable program as necessary to recruiting primary care, office-based physicians."
- "We've grown from two [hospitalists] in 2002 to 16; we have plans to recruit 10 more over the next three years."
- "We have a strong program at one of our facilities, which has led to the expansion of the program at two additional hospitals."

- "Our hospitalist program began in 1997; we currently have 47 staff physicians in the department of hospital medicine."
- "We have about 37 hospitalists, including internal medicine, general surgery, orthopedics, and neurology."

In past surveys, respondents have reported that an evolving clinical model has played a role in recruitment and retention. The leading strategy to attract and retain primary care physicians in the 2006 survey was "hiring hospitalists to reduce call schedule and hospital responsibilities."

In the 2007 supplemental survey, 86% of respondents reported that they had hired hospitalists or engaged with a hospitalist organization in the past year. Insights from those respondents centered on the expansion of hospitalist programs, as well as hospitalists' inclusion in subspecialties such as orthopedics and general surgery. ■

Editor's note: These data were pulled from the AMGA and Cejka Search 2007 Physician Retention Survey. Forty-three members of the AMGA, which collectively employs more than 14,705 physicians, completed the survey. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.