with surgical hospitalist programs, although there will never be as many surgical hospitalists as medical hospitalists because the demand for surgery isn’t as great.”

Although surgical hospitalist programs may still be relatively sparse across U.S. hospitals—with 200–300 spread out across the country in mostly community-hospital settings—experts say that will not remain the case for long.

Hospital medicine will experience déjà vu. Similar to 12 years ago, Nelson says, when private practice internists found it inconvenient or too time-consuming to see their patients in a hospital, specialty surgeons no longer find it practical to take calls from the hospital. This will likely lead to the rise of ambulatory surgical centers.

The surgical world evolves

Nelson, who has been studying the rise of hospitalist programs for 20 years, has witnessed specialty programs becoming more prominent in areas such as surgery, pediatrics, and obstetrics. Originally, he assumed there would be no place for surgical hospitalists—surgeries would always take place in hospitals, right? But that was before the growth of ambulatory surgical centers.

At ambulatory surgical centers, many surgeons take on surgeries that often come with scheduling and economic benefits, leaving hospitals with a vacuum for doctors who handle less profitable operations during odd hours. Since many surgeons take elective patients on a convenient Monday-through-Friday schedule at
Surgical hospitals

<continued from p. 1>

ambulatory surgical centers, hospitals are left with mostly emergency or trauma cases with a less profitable payer mix, Nelson says.

It all adds up to a changing world in which private surgeons no longer find it beneficial to be on call and come into the hospital for emergency surgeries, leaving hospitals wanting.

“The reason we got to where we were was poor reimbursement in Maryland and a shortage of surgeons who were willing and able to cover calls in the emergency room (ER),” says Gaurov Dayal, MD, vice president and chief medical officer at Shady Grove Adventist Hospital in Rockville, MD, who helped set up a surgical hospitalist program at Shady Grove two years ago. “Although it was built out of necessity, it’s been more successful than we anticipated and has helped improve patient care and expedite a lot of surgeries for hospital patients.”

Basic building blocks

Because most hospitals have yet to begin using a surgical hospitalist program, there is still some debate about the best way to create one. But following a similar path as other hospitalist programs has worked well for Shady Grove, Dayal says.

Tips for building such a surgical specialty program include:

- Hiring the right surgeons and explain the benefits of the position. One of the primary concerns involved in beginning a surgical hospitalist program is finding general surgeons to accept the position. Surgical hospitalists share plenty of the benefits that exist for general medicine hospitalists, Nelson says. But you may have to lay these out clearly to convince some surgeons to make the transition.

Creating a successful program starts with hiring surgeons who are willing to become invested in the program and able to work closely with the general medicine hospitalists and other hospital physicians, Dayal says.

Benefits of becoming a surgical hospitalist include:

- Interacting in an exciting atmosphere with more complicated patient conditions
- Seeing a wider variety of patients (i.e., patients of all ages and backgrounds that your practice might not typically see)
- Performing more surgeries
- Not worrying about creating your own referrals
- Focusing on patient care and not the business side
- Gaining financial backing from the hospital
- Flexible scheduling (e.g., working seven days on and seven days off)
- Experiencing the opportunity of working in a cutting-edge specialty area
Getting the support of other physicians in the area. When you speak with the physicians your hospital interacts with, it’s important to stress how your program will help rather than hurt them.

“You don’t want other surgeons in your area to see your surgical hospitalist program as more competition,” Dayal says. “That’s why it’s important to speak with them and to set boundaries.”

However, the most important thing to stress is that your program will not operate on patients seeking elective surgery and will exclusively exist for hospital patients, Dayal says. Explain to private surgeons that you will not take any private patients in order to get their full support.

Establishing an outpatient clinic. Your surgeons will be required to see patients for follow-up care at least once after surgery, Dayal says. To facilitate this meeting, the hospital will need to establish some type of outpatient clinic. Often, surgeons are able to do all their follow-up appointments in less than half a day, allowing them to spend more time performing surgeries.

To keep the boundaries clear, it’s important to note that surgical hospitalists should only see patients at the clinic for follow-ups and not for future consultations, and they should especially not see any new patients there.

“We often have patients who like the care they get from one of our surgical hospitalists and want to continue to see them for future care, but you really just have to give a recommendation of another area surgeon for your program to thrive,” Dayal says.

Not only would seeing private patients upset private surgeons, it would also dilute the amount of time your surgical hospitalists spend treating patients, he adds.

Patients win big

Because most surgical hospitalist programs spring from necessity—often with no monetary motivation behind them—the real beneficiaries are hospital patients, Dayal says.

In most cases, hospitals aren’t earning a profit by funding these programs, thanks to the extra hospitalist salaries on their books and a lower-reimbursement payer mix, Dayal says; but that doesn’t mean hospitals should be shy about such programs.

In the past, if a patient had appendicitis, the hospital would have to call for a surgeon, and it could take a while for someone to get there,” Dayal says. “Now, however, someone should be there or nearby 24/7, and the patient gets operated on much quicker. A side benefit to this is that it can clear out the ER faster because patients aren’t waiting in ER beds for a surgeon as long.”

Dollars and cents

Although financial rewards shouldn’t be a hospital’s main reason for starting a surgical hospitalist program, they may well pay off eventually, Nelson says.

“It’s a lot easier to make changes to your system if you have two or three surgical hospitalists than if you have 15 community surgeons doing all your surgeries,” he says.

Surgical hospitalist programs have the opportunity to be even more profitable as more and more hospitals move into a pay-for-performance system, Dayal says.

Hospitals would rather take the money they’re paying general surgeons for ER calls and invest it in a surgical hospitalist program where the surgeons are more devoted to the hospital, Nelson says, adding that surgical hospitalists are also much more likely to work closely with other hospitalists, simply because they’ll see them on a regular basis.

This is hugely beneficial for patients because it gets different teams working together and can help decrease the chance of communication errors.

Whether you already have the makings of a surgical hospitalist program or the need for one is only now becoming apparent, know that they will be growing in popularity and efficiency, Dayal says.

“I see surgical hospitalist programs at the same stage of their development that medical hospitalist programs were about 10 years ago,” he says. “They will just continue to pick up steam and will become the norm nationally in time.”
The inpatient medicine debate
Program value boils down to implementation
Mark V. Williams, MD, FACP, and Robert Centor take sides

It began as two colleagues in friendly debate and continued with separate articles and rebuttals in the Archives of Internal Medicine. Since then, these articles about the value of hospitalist programs—written by two industry leaders—have fueled a heated Internet debate about whether hospitalists actually improve patient care.

But when you look closely at the arguments, you begin to see the question isn’t really whether hospitalist programs are good for patients and hospitals, but instead how they should best be utilized.

“I believe there is sufficient evidence that hospitalist programs work … One of the main pieces of evidence is that it’s the fastest growing area in the history of American medicine and has quickly been embraced as the new model,” says Mark V. Williams, MD, FACP, professor and chief of the division of hospital medicine at Northwestern University Feinberg School of Medicine in Chicago. Williams wrote the article “Hospitalists and the Hospital Medicine System of Care Are Good for Patient Care,” published in June.

Seemingly on the other side of the argument is Robert Centor, professor of general internal medicine and associate dean of the Huntsville Regional Medical Campus at the University of Alabama. Despite Internet chatter implying that he opposes the hospitalist movement, Centor, author of the article “A Hospitalist Inpatient System Does Not Improve Patient Care Outcomes,” published in June, says hospital medicine has quickly grown and worked well for many hospitals. However, he says there is a risk of ineffective patient care in poorly constructed hospitalist programs. Simply putting a hospitalist program in place doesn’t mean anything if you aren’t doing it correctly. You have to be careful how you define hospitalists, who are really general internists who only see patients in the hospital, he says.

One thing Williams and Centor agree on is that in the changing healthcare world—with older patients and the increasing absence of private physicians—hospitals need a strong system in which general internists can see and treat patients in a hospital setting.

Williams’ words: The model now
“Hospitalist programs work and are necessary,” says Williams. The programs save time for hospitalized in-patients and can free time for primary care physicians. “When I was a resident, things were much different. Patients stayed in a hospital for a week or two regularly, but now it’s normally three or four days and out,” he says.

Although Williams says he would like to see more evidence on the effects of hospitalist programs on patient care and hospital finances, there are documented studies that hospitalist programs result in shorter lengths of stay and similar and/or improved rates of mortality; none of the studies showed that hospitalist programs resulted in worse outcomes than more traditional systems.

The question is no longer whether hospitalist programs work, Williams says. Instead, the question should be how to optimize their use. “We haven’t changed the delivery of care for many years, and we should now be focused on how to enhance that delivery,” he says.

Williams says the discussion should center on determining how to maximize the efficiency and standard of care in processes for treating heart failure, pneumonia, and other common ailments; ways to improve communication between hospitalists and primary care physicians; and postdischarge care.

“I want to make sure that when I discharge a patient, I’m not sending them into a black hole, and that they have a path to stay on and will continue seeing someone for follow-up appointments,” Williams says.

Centor’s concerns: A real fix?
Centor says he has no issue with the overall concept of hospitalist medicine, but he worries too many
hospitals today throw together make-shift hospitalist programs with no real plan simply to say they have one. He says he worries that some hospitals may create a hospitalist program because they feel everyone else around them is doing it, when, in reality, they may not need one.

“[Hospitalist programs] clearly have some major advantages, but I don’t want to see them shut out combo doctors [i.e., physicians who treat inpatients and outpatients at the hospital and in private settings] because that’s the best internist you can get,” Centor says. “It’s not very financially rewarding to be a combo doctor, but hospitals shouldn’t say no when a physician wants to do it.”

Cenort says physicians who want to treat patients in private settings and at the hospital have the advantage of knowing their patients better and providing for the most continuous coverage.

Hospitals do not solve problems by creating a hospitalist program if it doesn’t meet standards, Centor says. However, the problem is those standards do not yet exist. Organizations such as the Society of Hospital Medicine need to define the parameters of what a hospitalist program should be.

The Holy Grail

“If you don’t set up a hospitalist program correctly, it won’t deliver good care, just like anything in life,” says Williams.

But what is a good hospitalist program and what is a bad hospitalist program? Williams and Centor agree on many of the key points.

“A good hospitalist program has good doctors,” says Centor. “Good doctors know what they know and when to get help. They have good bedside manner and work with other doctors. They also understand hospital performance and want to be involved in quality.”

Williams and Centor say a good hospitalist program must have the following infrastructure:

- Constant communication between the physician, nurses, the patient, and other staff members during admission, the stay, and discharge
- At least one internist on-site at all times
- Good communication between the hospital and primary caregivers
- Involvement in hospital quality care initiatives
- Assessment of patients on admission for likelihood of readmission
- Proper patient-physician mix (an average of 12–15 patients per physician)
- The hospital’s financial backing
- Continuity in the program over time; ideally, physicians will want to stay to maintain the program
- Schedules that don’t lead to burnout

Hospitalists should also partner with nurses and pharmacists for the most efficiency, Williams says.

“Hospitalists improve the ability to have this type of teamwork because they don’t just come in and leave,” he says. “They can round with nurses and pharmacists so patients see a team of people that are focused on moving that patient’s care forward, while reducing the chances of communication issues.”

As a patient, which would you prefer: a team of people asking and answering medical questions all at once, or answering the same questions from three separate groups?

Where too many hospitalist programs go wrong is focusing on trying to make a profit and overextending their hospitalists by making them work too many hours and seeing too many patients, Williams says.

“A bad hospitalist group can be a disaster,” Centor says. “If it’s not under the right leadership, it ruins the efficiency and doesn’t fill the need that it’s meant to.”

Too many internists that become hospitalists get burnt out quickly because of their schedules and lack of planning by the organization. “You have to be able to create a schedule and have the right number of internists so that people can take time off and you still get good coverage,” Centor says. “Working in a hospital full time is really hard work, but it can be enjoyable if it’s the right atmosphere.”

“If we’re able to improve quality and maintain efficiency, that’s the Holy Grail,” Williams adds.
New study

ED-to-inpatient transfers are flawed with safety gaps

Why one-quarter of ED-to-inpatient transfers are near misses

For years, the inpatient medicine leaders at Yale-New Haven (CT) Hospital (YNHH) fielded complaint after complaint from house staff members and hospitalists about new admissions from the emergency department (ED). Both groups complained of poor communication. What might seem like cross-specialty bickering actually is something more serious. As the hospital leaders were aware, ED physicians were becoming increasingly frustrated with their inability to reach internal medicine (IM) physicians to safely transfer care of patients because of their busy schedules.

More than one-quarter of patients transferred from the ED to IM experience an adverse event or near miss, according to a recent study, “Dropping the Baton: A Qualitative Analysis of Failures during the Transition from Emergency Department to Inpatient Care,” published in the Annals of Emergency Medicine and conducted by the hospital. Twenty-nine percent of the 139 respondents reported an adverse event or near miss related to the ED-to-inpatient handoff, according to the study.

“ED and IM leaders debated several proposed solutions, but we quickly realized that we didn’t exactly understand what was going wrong and why,” says Leora Horwitz, MD, MHS, associate medical director of Center for Outcomes Research and Evaluation at YNHH.

A search for answers

Like many healthcare organizations, communication gaps exist between different specialties of care providers at YNHH. Although a common problem, there is little existing literature to guide organizations. “Most of the work to date has focused on patient transfer within the same specialty, such as shift-to-shift handoffs. Much less work has been done to evaluate handoffs between specialties, one of the most common being the ED-to-medicine transfer,” says Nidhi Shah, MD, MPH, hospitalist attending physician and chief medical information officer at YNHH.

As part of the YNHH research team, Horwitz and Shah closely examined the vulnerable aspects of ED-to-IM transitions within their organization to identify potential deficiencies in care that they hoped to solve.

The survey spots a red flag

After designing its own survey on ED-to-IM transitions, YNHH administered it to every physician or physician assistant who provided or received a sign-out slip about patients transferred from the ED to the inpatient medical units. That list included every ED house staff member, ED physician assistant, IM house staff member, and IM hospitalist. Researchers chose these staff members because they are the “frontline staff,” as Shah calls them (i.e., those with significant insight into the handoff process). In addition, all the hospitalists were targeted for the survey particularly because YNHH has a separate hospitalist medicine service unconnected to the teaching service.

“They are in the best position to know what is and what is not working in a process because they live it every day,” Shah says.

Although only half of the selected staff members completed the survey, YNHH still garnered plenty of useful information. Specifically, 29% of responders reported that a patient had experienced an adverse event or near miss after ED-to-inpatient transfer. These 40 respondents described specific incidents of errors: diagnosis (13), treatment (14), and disposition (13), after which patients experienced harm or a near-miss event. Six patients even required an upgrade from the floor to the ICU.

What was the cause? Many surprisingly responded by describing a variety of safety gaps that affected the transfer of patients from ED to IM floors, not just direct communication errors, Horwitz says.
Participants identified the following problematic areas:
- Communication within the ED
- Communication between the ED and IM
- Environment of the ED and hospital (physical space, crowding, workload)
- Information technology
- Flow of patients from the ED to the floor
- Assignment of responsibility for patients and results

ED speak vs. IM talk
In addition, researchers learned that ED staff members were not as aware of adverse events as their IM counterparts; only 13.5% of ED respondents said they knew an adverse event occurred after the transfer process, compared to 38% of both hospitalists and medicine residents.

“Even restricting ourselves to communication—our original interest—we were interested to see that failures were not solely (or perhaps even typically) due to lack of content, which is what people typically assume is a communication failure,” Horwitz says.

Rather, a variety of factors played into miscommunication, including the following variables:
- Conflicting expectations about what content each side should convey
- Mutual misunderstanding of job roles
- Pronounced bias and mistrust of other specialties
- Insufficient prioritization of real-time interaction

Because the roles of ED and IM doctors differ, they tend to be concerned with different objectives and ask different questions.

The role of an IM physician is primarily to definitively determine a patient’s diagnosis and initiate the proper long-term treatment, Horwitz says. The role of an emergency physician is to assess and maintain the patient’s current stability.

“We found that internal medicine and emergency physicians did not always appreciate these fundamental role differences, creating or exacerbating communication failures,” Horwitz says.

One oversimplified example is if a patient with shortness of breath presents to the emergency room, ED physicians would first ask themselves the following questions: How sick is this patient? Does he or she belong in the ICU or on a regular unit? Does this patient have a medical problem or a surgical problem? Where should I admit this patient? ED communication at YNHH was thus often focused around these key issues.

IM physicians, on the other hand, wanted to hear whether this patient had heart failure or pneumonia. “These sorts of conflicting expectations were a setup for mutual frustration and negative stereotyping,” Horwitz says.

Which specific factors led to adverse events?
The study identified several factors responsible for the adverse events. Omission of pertinent patient data played a role, most commonly following omission of the most recent vital signs.

Environment played a factor too. When the ED was crowded, handoff communication was rushed, and there was less opportunity for interaction between the sending and receiving team, Shah says.

Recommendations from The Joint Commission
In July, The Joint Commission announced its 2009 Hospital National Patient Safety Goals. The agency recommends the following steps to improve staff communication in healthcare facilities:
- Repeat spoken or phone orders to the person who gave the order.
- Create a list of abbreviations and symbols not to be used.
- Quickly get important test results to the proper staff person.
- Create steps for staff members to follow when sending patients to the next caregiver. These steps should help staff members explain the patient’s care. Make sure there is time to ask and answer questions.
Safety gaps  < continued from p. 7

was also identified as a vulnerability in the transfer process.

“For example, if a patient was booked to a medicine team but continued to board in the ED while waiting for a bed, sometimes additional test results to assess the patient’s current condition during the wait period was not communicated back to the receiving team,” Shah explains.

Tips for improvement

Horwitz suggests the following tips to improve communication failures:

➤ **Improve intraspecialty relations to reduce stereotyping and bias.** Clarify roles and responsibilities. Hold a monthly ED-IM joint conference to discuss a case study. Conduct intraspecialty social events. Promote cross-training rotations in the ED for IM staff members.

➤ **Train hospitalists and house staff members to provide and receive sign-out consistently and more accurately.** Emphasize higher-order content, such as the degree of certainty about the diagnosis, important pending information, and response to treatments initiated in the ED. De-emphasize factual content that is readily available from the chart or computer system. Design audit and feedback methods especially for trainees.

➤ **Make the ED personnel involved in failed transfers aware of this information immediately.**

➤ **Be creative about workload.** Consider taking on fewer admissions to limit the stress of on-call days. Overworked physicians can hand off work to underutilized physicians during the shift, and not after the shift is over. Replace numeric pagers with alphanumeric pagers and alphanumeric pagers with phones.

➤ **Prioritize discharge work earlier in the day to ease the burden on the ED.**

➤ **Take responsibility for giving sign-out information to the new team member if a patient is rebooked from someone else on your team.**

➤ **Remember long-term boarding patients.** Pay particular attention to those likely to require continual intervention (e.g., asthmatics).

➤ **Distribute official policies about responsibility for boarding patients, pending data, etc.**

➤ **Institute pager forwarding, team pagers, or computerized assignment of responsibility to all staff members.**

Case study

Develop a smarter training program

*How the University of Colorado turns IM residents into hospitalists*

Feeling underprepared to respond to a clinical encounter can be jarring to a new physician, especially one who thrived as a resident.

**Jeffrey Glasheen, MD,** remembers the feeling well. As the current director of the hospital medicine program and hospitalist training program at the University of Colorado School of Medicine in Aurora, Glasheen was a residency program standout who felt underprepared when he became a hospitalist.

Glasheen learned that the program was designed to train physicians in internal medicine (IM), not necessarily a hospitalist.

This kind of incomplete traditional IM training can leave residents ill-equipped for a career in inpatient medicine and can lead to unnecessary dropouts. In fact, the highest turnover rate for hospitalists occurs within the first two years on the job, says **Eric Siegal, MD,** former regional medical director at Cogent Healthcare.
in Brentwood, TN, and now a critical care fellow at the University of Wisconsin. Siegal and Glasheen coauthored the article “Fulfilling the Promise of Hospital Medicine: Tailoring Internal Medicine Training to Address Hospitalists’ Needs,” published in the *Journal of General Internal Medicine* in July.

Although some turnover is inevitable, many hospitalists complain that “it’s just not the right job for me” on their way out the door, Siegal says.

“Most graduating residents are smart and resourceful people, and many of them adapt quickly and effectively to their hospitalist positions,” he says. “However, there are some recurring areas of failure.” Some of these areas are geriatrics, neurology, perioperative care, and consultative medicine.

For the past five years, Glasheen has worked to create a successful hospitalist training program at the University of Colorado that prepares students for the specific challenges they will face as hospitalists. He says it is the longest-running hospitalist training program in the country.

“We know this is important, and we wanted to share this nationally,” he says.

**The study that started it all**

Glasheen began working as the first academic hospitalist in the University of Colorado system in 2000. Almost immediately, he felt uncomfortable in the position, and he soon discovered his friends in other programs felt the same way.

“I felt underprepared to do the job, and that was weird,” he says. “I felt like I must’ve missed something in residency, because I was asked to do different things that I wasn’t prepared to do.”

Glasheen started researching the topic of underprepared hospitalists out of residency. He soon discovered a 2001 *American Journal of Medicine* study written by Plauth et al, “Hospitalists’ perceptions of their residency training needs: Results of a national survey,” which looked at 389 randomly pooled internal medicine–trained hospitalists.

Researchers found that residents-to-hospitalists felt underprepared in clinical and nonclinical areas. Survey respondents said their training did not prepare them adequately in several clinical areas, including:

➤ Geriatrics
➤ Neurology
➤ Perioperative care
➤ Consultative medicine

Researchers also found significant educational mismatches in the following nonclinical areas:

➤ Systems issues (quality improvement [QI], health-care finance, utilization review, practice guideline development)
➤ Continuums of care (coordination of care between settings prescribing the appropriate level of postdischarge care)
➤ Ethics of palliative care and principles of advance directives

Further, respondents believed their training overemphasized the medical procedures needed for the practice of hospital medicine. But the training didn’t rigorously cover the procedures a hospital performs today.

**Teamwork: Today’s training solution**

Glasheen says the Plauth study provided definitive evidence that the hospital medicine group needed to develop a specific training program for hospitalists. Next, he had to do some legwork.

“If we’re going to train people to be an effective hospitalist, we should know exactly what a hospitalist does,” he says. “No one had really looked at that.”

In a study authored by Glasheen and colleagues and published in the *Archives of Internal Medicine* in 2007, “The spectrum of community-based hospitalist practice: A call to tailor internal medicine residency training,” the hospital medicine group systematically studied 140,000 patient encounters, specifically eyeing the services for which community hospitalists were billing.

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Case study < continued from p. 9

The group found that approximately 30% of what hospitalists do consists of neurology, orthopedics, and general surgery, and that about half of their patients were older than 65.

With that information, Glasheen began shaping a new training program for hospitalists.

**Tip:** Conduct a similar internal investigation to determine exactly what work your hospitalists are doing; this should help focus your training. The work of your hospitalists may differ slightly based on several factors, including patient population and geographic location.

Build your hospitalist program with the following initiatives in mind:

- **Multidisciplinary clinical team.** Hospitalists’ training is missing a basic component in residency training: learning how to function as a part of a multidisciplinary clinical team.

  For example, if you have a simple dosing problem with obese patients or those with chronic renal insufficiency, having a pharmacist on your team can benefit everyone. Traditional IM training expects its graduates to be competent or master all these elements without needing to defer to specialists.

  The reality, Glasheen says, is that no one can be an expert in everything. “I need to know a lot about medications, but why wouldn’t I have an expert in that field assisting? It doesn’t mean I can forget about it; it’s just about taking advantage of everyone’s expertise,” he says.

  Work hour changes for residents have recently worsened the problem. Physicians are required to become experts in more fields—and in less time—than they were a generation ago. This makes it increasingly important to develop an all-star clinical team and train those on the team to defer to others when appropriate.

  “We’ve got to get past the heroism of the individual doctor and move to a team sport,” Glasheen says. “It’s no longer about the star player. That’s when you start to achieve the nirvana of healthcare.”

- **Comanagement.** Another important piece of training is educating residents about the difference between comanagement and consultations, both of which they will undertake as hospitalists.

  Consultation means giving advice to a physician who has questions about a patient, whereas comanagement means actively sharing the responsibility of patient care.

  Knowing the difference can help alleviate job stresses, including legal disputes for the hospital, Glasheen says.

  For example, you, as the hospitalist, might put a patient on anticoagulation medication. But if the surgeon didn’t want that, you’re in trouble.

  This ineffective communication might occur in cases of comanagement. Your program must address comanagement as a real and important aspect of the hospitalist job.

- **QI.** This should be another focus area. About 86% of hospitalist groups are currently involved in QI projects, Glasheen says.

- **Advanced specialties.** Two additional important clinical areas are elderly care and palliative care.

  “I always felt palliative care is a skill that is really easy to be bad at because people don’t typically recognize that they’re bad at it,” Glasheen says.

  To assist organizations in designing their programs, Glasheen included the following four guiding principles in his paper:

  - Find a balance in training to accommodate limited resident work hours and a declining interest in generalist careers. In other words, make the best use of the training hours you have.
  - Build an operational improvement methodology into your clinical curricula. Although administrators believe one of the hospitalists’ job priorities is to improve processes, most physicians do not have the skills necessary to develop and deliver significant process changes.
  - Emphasize process over clinical improvement.
Residents can learn clinical medicine and pathophysiology through their training. Emphasize process concerns that aren’t typically taught on traditional ward rotations.

- Listen to all interested parties when restructuring inpatient training. An effective hospitalist training program will rely upon other specialties to provide training opportunities and expertise useful to a hospitalist.

**The University of Colorado program model**

Residents at the University of Colorado School of Medicine serve one year of general medicine. At the beginning of their second and third years, they can choose to become a hospitalist resident and substitute seven hospitalist-focused rotations instead of the more traditional categorical offerings.

Utilizing a better model of care for elderly patients, rotations include an acute care for the elderly service for two months that admits all patients older than 70, a hospitalist preceptorship, a consultative/peroperative/stroke rotation, and a QI month.

Each of the two months that residents spend on this service includes one week working with the palliative care service. They conduct a nursing home visit and a follow-up clinic visit with at least one patient they discharged.

The hospitalist faculty also holds an annual palliative care retreat in the mountains outside Vail, CO. The goal of the retreat is to cover core palliative care concepts and end-of-life ethics and decision-making. Another important result is that the residents have some fun and bond with each other and the faculty in a manner that is not possible in the hospital setting.

The preceptorship rotations primarily aim to teach residents how the hospitalist job works so they get a sense of what it really entails. They tend to work a five-days-on, five-days-off schedule and admit patients every day while simultaneously performing consultative work and observation unit care. The other major component of the preceptorship involves teaching residents the nuts of hospital medicine, including billing and coding, developing efficient rounding techniques, and handling large inpatient services, Glasheen says.

Preceptor residents also do daily resource rounds, and the educational experience is thorough. For example, they must review the lab tests they ordered to determine the question they were trying to answer with the test, the characteristics of the test for answering that question, how much the test cost, and whether they would order the test again in a similar situation.

In their third year, residents go through the same training regimen, except they dedicate a month strictly to QI, learning how to identify a problem, do process mapping, and find a solution. “This is a tool they can take to their next employer,” Glasheen says. “They can say, ‘Not only do I want to do this type of work, I also know how.’ ”

**The Cogent Academy model**

The closest experience to hospitalist medicine that residents find is the traditional ward medicine rotation, and graduating residents assume that if they enjoyed ward medicine, they’ll enjoy being a hospitalist.

“I’d say that that’s about 75% true,” Siegal says. “There are many similarities between the two, but there are distinct differences as well. I suspect that graduating residents who have targeted training in hospital medicine will have a better understanding of what the job entails, and will therefore be more likely to stay in the profession.”

Employers such as Cogent, Sound Inpatients, and IPC The Hospitalist Company value targeted training in their physicians. In its absence, they have created training programs that attempt to quickly indoctrinate new hospitalists and fill in the worst training gaps, Siegal says. For example, Cogent has a three-day “Cogent Academy,” which is essentially an intense hospitalist boot camp.

“While I think highly of Cogent Academy, it’s obviously no substitute for one or two years of targeted hospitalist training during residency,” Siegal says. “Only the largest hospitalist companies can afford to provide such...”

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As an employer, Siegal says he would prefer candidates with targeted training because:

- They would presumably require less training and mentoring from day one and would become productive more quickly
- There is a lower likelihood of clinical and/or interpersonal gaffes due to inexperience with the model
- It implies a higher level of commitment to the profession and a higher likelihood of retention

Recruiting tip of the month

Create partnership for successful selection

A prominent Northeast hospital cardiology group with a long-standing reputation in the community sought to hire a physician.

At the beginning stages of the search, the hiring team of this single-specialty group, located in a rural area, felt that their ideal candidate would be a younger physician familiar with the region with three years of experience.

The hiring committee needed a partner to work with their schedule and help facilitate the search. Cejka Search joined their team to promote this competitive job opportunity and implement a successful hiring process.

Strategy

Developing a partnership with the hiring team is essential to creating a cohesive recruitment process. By joining the team and embracing the organization’s goals and desired outcomes, Cejka Search earned the leverage to offer advice to other team members.

Cejka Search used that leverage, encouraging the hiring team to open up the selection parameters by seeking candidates beyond the regional parameters of the Northeast area and increasing the number of years of experience required. This created a greater pool of candidates, as well as a sense of urgency to the search.

Cejka also recommended revising the compensation package. Other organizations seeking candidates for similar positions offered higher compensation packages and a signing bonus. Since the hiring process is primarily candidate-driven, the position’s benefits needed to keep the potential physician’s expectations in mind. Presenting a more competitive offer attracted more applicants.

Results

By reevaluating the criteria for the position, the recruitment team succeeded in hiring a doctor from the West Coast with more than 15 years of experience who received a higher compensation package. Within one year, two more cardiologists were also recruited. Because of this successful partnership, Cejka Search is now collaborating with the group to create a similar hiring process for a vascular surgery position.

The partnership between the two organizations of the hospital and Cejka Search resulted in a unified recruitment process, a better understanding of what candidates want, and a successful placement for the job position.

Editor’s note: This month recruitment strategy was submitted by Susan Anderson, a consultant of Cejka Search. For more information, visit www.cejkasearch.com or call 800/678-7858.