Launching a pediatric hospitalist program: Weighing pros and cons

Key considerations in assessing program readiness

Pediatric hospitalist programs, similar adult hospital medicine programs, are multiplying as more referring pediatricians and their patients recognize the benefits of the hospitalist model of care. But could—and should—your hospital support a pediatric hospitalist service?

Note: The American Academy of Pediatrics (AAP, www.aap.org) reported in 2002 (the latest data available) that approximately 40% of office-based pediatricians were affiliated with hospitals that employ pediatric hospitalists. In addition, the Society of Hospital Medicine (SHM) notes that of the roughly 12,000 hospitalists in practice today, 9% specialize in pediatrics.

Roles vary
Although the job description varies by hospital, pediatric hospitalists provide a wide range of patient care to hospitalized patients up to 21 years old and also care for premature infants with the aid of specialists. Jack M. Percelay, MD, MPH, FAAP, is the director of the pediatric hospitalist service

Solving the pay puzzle
Four tenets of a successful compensation model

Recruiting hospitalists is challenging in today’s job seekers’ market and is often made tougher by budget constraints and other finance issues. When it comes to snagging the best hospitalists, however, compensation is a critical factor not to be overlooked.

It is essential for healthcare organizations—especially those starting a new hospitalist program—to ensure that their compensation is at market level. This entails regularly researching compensation trends, consulting appropriate organizations such as the Society of Hospital Medicine (SHM) to determine the current market rate, and being prepared to offer at least that rate to prospective hospitalist candidates.

According to Stacy Goldsholl, MD, national medical director for Irvine, CA–based hospitalist company Cogent Healthcare (www.cogenthealthcare.com) and an SHM board member, there is more to it than simply ponying up when it comes to hospitalists’ salary offerings.

She stresses that a successful compensation model
- is competitive for your local market
at the Virtua Health System based in Marlton, NJ, the SHM’s pediatric board member, and the former chair of the AAP’s Section on Hospital Medicine. His pediatric hospitalists commonly treat ailments ranging from asthma, pneumonia, and dehydration to meningitis and respiratory problems.

In addition, Percelay says pediatric hospitalists often assist in the care of medically complex children, children who need postoperative care, and those with cardiology, gastrointestinal, and pulmonary problems. In some facilities, pediatric hospitalists also work in the emergency department and pediatric intensive care unit in collaboration with pediatric intensivists.

Pediatric hospitalists share clinical expertise with pediatricians and share the business view of hospital medicine with their adult hospitalist colleagues, says Percelay. In particular, he notes, “We’re becoming more involved with the systems aspects of hospital medicine.”

Systems-based responsibilities of pediatric hospitalists often include
- coordinating the transition of pediatric patients to the outpatient setting
- understanding and effectively using the full spectrum of resources at the hospital or outside health-related agencies
- arranging for home health support for pediatric patients posthospitalization
- helping the facility realize financial savings (e.g., length of stay management)

**John R. Schreiber, MD**, head of pediatrics at the University of Minnesota Children’s Hospital, Fairview, says the overall complexity of inpatient pediatric care is much greater than it used to be, which has helped shape pediatric hospitalists’ role. “Children who are admitted tend to be much sicker today. A lot of children aren’t admitted anymore for common illnesses because [referring pediatricians] are able to handle them on an outpatient basis.”

Schreiber says another key role pediatric hospitalists fill is keeping up-to-date with technology and clinical expertise in the hospital, which is especially important when complications arise. “A hospitalist service enables [referring pediatricians] to efficiently admit patients and see to it that they receive high-quality care so PCPs can spend their time in ambulatory medicine where they are needed most,” he says.

**Trends spurring growth**
According to Percelay, the pressures of managed care initially drove the growth of pediatric hospitalist programs, but today quality issues motivate more hospitals to establish them.

With children inpatients sicker than they were 10–15 years ago and office-based physicians busier than ever, “it’s extraordinarily valuable to have someone who is in the hospital full-time taking care of hospitalized children,” he says. “It adds a quality of care level that’s hard to replicate when you’re managing a patient from your office.”

**The groundwork for starting a program**
A hospital that is contemplating whether to support a pediatric hospitalist service first must accurately examine pediatric patient volume, according to Percelay. That entails asking questions such as, “Do you have enough work, resources, and revenue so you can support a pediatrician or a group of pediatricians to manage your inpatients?” he says.

In addition, both Percelay and Schreiber recommend addressing the following questions when assessing the need for a pediatric hospitalist program:
Who will staff the group?

Percelay stresses that in most cases a hospital with an existing adult hospitalist program will need to hire a completely different group of physicians for a pediatric program. “You’re effectively starting a whole new program. It might share some infrastructure, but the personnel are all going to be new and different,” he says. Although pediatric hospitalists exclusively staff the vast majority of pediatric hospital medicine programs, Percelay notes that programs successfully use “med-peds”—internal medicine/pediatric-trained physicians—to care for both adults and children.

Note: An article in the April 8, 2005, Medical Economics (www.im.org/MPPDA/wheredomedpedsfit. pdf) describes med-peds as physicians who go through the typical four years of residency but then take board exams in both internal medicine and pediatrics and eventually pursue recertification in the two specialties simultaneously.

Kenneth G. Simone, DO, founder and president of Hospitalist and Practice Solutions in Brewer, ME, says some hospitalist programs are also staffed with family practitioners and med-peds who can cover both the adult and pediatric inpatient programs. “Some hospitalist programs that are adult in nature will use these practitioners to cover pediatric patients as well. This model could make a pediatric program more affordable and perhaps more sustainable,” he says.

What is the local “climate” for a program?

Another key consideration for hospitals is accurately determining the needs of pediatricians in the community, says Percelay. This includes gauging what he calls the political climate for a program. “What is the desire and feeling of the referring physician groups and what is the culture of the institution? Are the [local] pediatricians ready to accept hospitalists?” he asks.

He notes that once an adult hospitalist program has been established locally and works well for referring primary care physicians, pediatricians can see that their fears (e.g., concerns about loss in continuity or quality of care) are unfounded. In fact, Percelay has seen instances in which local pediatricians have witnessed the success of adult hospital medicine programs and then pushed for the establishment of a pediatric service.

Will the program offer a better level of clinical care?

Chief on Schreiber’s list of considerations is whether a pediatric hospitalist program will improve care. “The reasons to establish a pediatric hospitalist service are several. It’s to improve access to complex tertiary care for the whole community, there is an educational role in that...”
Pediatric hospitalists work very closely with resident physicians, and there is obviously a superb clinical care role.”

In particular, Schreiber cites the nationwide shortage of specialists as a potential reason that a pediatric hospitalist program could be of value to referring physicians.

“I think the [case for starting a program] is going to be very strong, particularly at large children’s hospitals where there is a complexity of care that requires superior organization and superior relationships with the community. A hospitalist who is well-trained can meet those roles,” he says.

Could pediatric hospitalists fill other important and unmet needs? The organization of care for children is complex and often involves multiple pediatric specialists and other supporting providers. According to Schreiber, another advantage of the pediatric hospitalist is that he or she can often better coordinate care for patients.

“The hospitalist can be the primary care provider so parents can focus on one person, instead of having 10 consultants coming through and confusing them. It allows better family-centered care,” he says.

Avoiding pitfalls when creating a program

As veterans in setting up pediatric hospitalist programs and guiding new ones through the critical early stages, Percelay and Schreiber caution against the following pitfalls:

- **Don’t force the growth of a program.** Percelay advises hospitals to allow referring pediatricians to accept the program at their own rate. “Make sure that if you are starting [a service], you’re willing to support its growth and not be overbearing in searching for business,” he says.

- **Be careful not to underestimate growth.** Both Schreiber and Percelay say timing and staging the program’s growth are critical. Although hospitals should not begin a program with an agenda that is too aggressive, they must also take care not to understaff it, Percelay says. “If there is a very strong desire on the part of pediatricians to use pediatric hospitalists to take over many of the unclaimed responsibilities in the hospital, a new program can quickly become overwhelmed.” Schreiber found that the volume of patients at his facility spiked quickly at the outset and, as a result, strained the service’s infrastructure. “If you do it well, your volume will increase, and you should be prepared for that,” he notes.

- **Don’t go it alone.** Instead, look to other successful pediatric hospitalist programs for advice. Schreiber notes that his current hospital director visited Rainbow Babies and Children’s Hospital in Cleveland (Schreiber’s former hospital) and Cincinnati Children’s Hospital to meet with pediatric hospitalists and learn their systems. “He came back with that knowledge and developed our own unique system at the University of Minnesota Children’s Hospital,” Schreiber says.

Outlook

Schreiber says he anticipates a bright outlook for the growth of pediatric hospital medicine. “Specialists like [the service] because the hospitalists organize the various consultants around a patient, the patient and families love it because there is always a person who is accountable each day, and the referring physicians love it because they have access to a faculty person 24 hours a day.”

Although Percelay also sees wide opportunity for the field, he notes, “It’s clear that a pediatric hospital medicine program will not work in every community. There are going to be programs that choose the more traditional model of physicians doing both inpatient and outpatient care.”

**Editor’s note:** If you would like more information about setting up a pediatric hospitalist program, contact Percelay at jackpercelaymd@yahoo.com or Schreiber at jrs@umn.edu.
Pediatric hospital medicine: Subspecialty or interest area?

The establishment of the American Academy of Pediatrics’ (AAP) Section on Hospital Medicine (SOHM) in 1999 boosted the recognition of pediatric inpatient medicine and created an official forum for general pediatricians, pediatric hospitalists, primary care pediatricians, and others interested in the areas of

- pediatric inpatient education
- policy
- membership
- communication
- research

In 2005, the Society of Hospital Medicine (SHM) added a seat on its board of directors specifically for a pediatric hospitalist. **Jack M. Percelay, MD, MPH, FAAP,** director of the pediatric hospitalist service at the Virtua Health System in Marlton, NJ, is currently serving the first term, which is one year. The post will expand to a three-year term beginning in 2006, according to the SHM.

Percelay says pediatric hospital medicine remains a specialty interest area within pediatrics and is not yet a full subspecialty—which is not surprising considering that debate continues over whether adult hospital medicine programs should seek specialty status. Specialty or subspecialty status conferred by the American Board of Medical Specialties would mandate that hospitalists seek additional training and become certified.

**SOHM guidelines**

In April 2005, the AAP published the policy statement Guiding Principles for Pediatric Hospitalist Programs, which provides the following overview of such programs and their expected benefits, according to the guidelines:

*Pediatric hospitalist programs have become increasingly popular recently, emulating the growth and success of adult hospitalist programs . . . Adult hospitalist programs have been well-studied and demonstrated to provide high-quality outcomes with decreased average lengths of stay and decreased costs while maintaining both patient and referring-physician satisfaction. Emerging pediatric hospitalist data reflect similar results.*

The guidelines further state that despite wide variations in the clinical responsibilities of pediatric hospitalists from site to site, a uniform set of principles can be identified. As a result, the SOHM identifies the following six principles for establishing pediatric hospitalist programs:

1. All pediatric hospitalist programs should be based on voluntary referrals. Pediatricians and other qualified primary (or specialty) care physicians should always retain the option to admit and manage their patients. They should also retain the privilege to accept and participate in unassigned patient admissions at their desire or discretion.

2. Each pediatric hospitalist program should be designed to meet the unique needs of the patients, families, and physicians in the community it serves.

3. Physicians who serve as hospitalists should be board-certified in pediatrics or have equivalent qualifications.

4. Pediatric hospitalist programs should include in their design provision for appropriate outpatient follow-up of patients on discharge.

5. Pediatric hospitalist programs should provide for timely and complete communication between the hospitalist and the physicians responsible for a patient’s outpatient management, including the primary care physician and all involved subspecialists.

6. Pediatric hospitalist programs should include data-collection and outcome-assessment capabilities to monitor their performance and are encouraged to contribute to research studies involving the care of hospitalized children.

*Editor’s note: To access the complete SOHM policy statement, go to http://aappolicy.aappublications.org/cgi/reprint/pediatrics;115/4/1101.pdf.*
Compensation model

- includes a fixed and a variable component (i.e., base plus bonus) to attract, retain, and incentivize hospitalists
- is simple and easy to administer
- includes incentives that are aligned with the hospital or other employer (e.g., multispecialty group, hospitalist management company, etc.)

Goldsholl—along with Jeffrey Dichter, MD, FACP, director of the hospitalist program at Ball Memorial Hospital in Muncie, IN—spoke November 15 during the live audioconference, “Hiring Hospitalists: Proven Strategies for Recruitment, Retention, and Competitive Compensation,” sponsored by HMA publisher HCPro, Inc., based in Marblehead, MA.

Local ‘supply’ affects value

According to Goldsholl, assessing fair market value is one of the primary tenets of a solid compensation model. Market value is an independent factor based almost solely on local supply and demand, which means that a “competitive” salary in Charleston, SC, for example, will be quite different than a competitive salary in Decatur, AL.

“In today’s hospitalist market, demand is grossly out of proportion with supply,” she said. To demonstrate, Goldsholl cited both anecdotal evidence (e.g., the large number of recruitment ads in hospitalist-targeted publications) and a presentation during the SHM’s annual meeting in Chicago in April given by Robert Wachter.

Note: Wachter, associate chair of the University of California at San Francisco’s Department of Medicine, coined the term “hospitalist” and remains a leader of the hospital medicine movement.

In his presentation, Wachter asserted that former projections, based mainly on the results of the SHM’s 2003 Hospitalist Productivity and Compensation Survey, predicted a need for 30,000 hospitalists by 2010. However, he and a growing number of other leaders in the field now estimate that approximately 50,000 or more hospitalists will be needed by then.

“That means there are roughly five jobs for every practicing hospitalist in the United States today, clearly making it a buyers’ market,” Goldsholl said.

According to Goldsholl, the primary reasons for the discrepancy are the drastic expansion of hospitalists’ roles during the past three years and the fact that their role in surgical comanagement was originally overlooked. For example, hospitalists in many facilities now regularly work with orthopedic surgeons, neurosurgeons, and other surgical specialists to co-manage patients before and after surgery.

A two-faceted salary structure

In Goldsholl’s second tenet of a successful compensation system, she recommended that hospitals offer a compensation package with both a fixed and variable component. “This means offering a base salary that will attract the best hospitalists, but also offering a variable or bonus portion to motivate the hospitalist to perform at the level you expect and the level the client [i.e., hospital, multispecialty group, referring physician, etc.] expects.”

Another consideration with regard to salary packages is the relative youth of hospitalists, Goldsholl said. “Today’s hospitalists, who average just 37 years old, seek a competitive base salary that is not at risk.” Specifically, she said it appears that generations X and Y physicians (those born after 1965) are not willing to work in a productivity-only compensation system. They simply view it as too risky.

Simplicity rules

Although basing the variable portion of a hospitalist’s salary on only one metric is probably not a good idea, hospitals should also avoid using a complex system of factors that determine a bonus or other incentive-based pay.

“The compensation model should be simple. You don’t want to spend a great deal of administrative time looking through a lot of metrics. You want something that is simple, objective, and easy to [administer],” Goldsholl advised.
Aligning incentives
Goldsholl’s fourth tenet of a successful compensation model begins with identifying the organization’s specific needs, which will likely vary depending on whether the hospitalist is hospital-employed or hired by a private group or works in a large academic medical center.

For example, is it an administrative goal to decrease length of stay, use hospitalists to teach residents, or expand hospitalists’ role to comanaging surgical patients?

Once the organizational goals are known, the areas for which well-performing hospitalists should be rewarded can be identified.

Waiting for new data
Goldsholl noted one big hurdle with regard to compensation data: The field still uses information gathered in late 2002 and published in 2003 (the last time the SHM conducted its Hospitalist Productivity and Compensation Survey).

That survey polled 300 hospital medicine groups representing approximately 2,000 hospitalists and found that

- median base salary was $140,000
- median bonus was $18,000
- median total work hours were approximately 2,800
- median benefits totaled $25,000
- 61% of hospitalists reported receiving a bonus
- 8% of hospitalists reported being compensated by productivity alone

A new SHM survey is due out in early 2006. However, because hospital medicine has changed so drastically during the past several years, it remains to be seen what compensation structures currently rule, said Goldsholl.

Finally, she noted, “Hospitalists are quickly approaching the level of compensation for emergency medicine physicians, but no one knows where the ceiling will be. With the disproportionate levels of supply and demand, I expect that [the 2006 survey] will show an increase in compensation.”

Tip: SHM members can participate in the 2006 compensation survey or check the progress of the organization’s targeted 400 responses at www.hospitalmedicine.org.

Communication is key to a sound hospitalist program

There is no shortage of studies demonstrating that effective communication not only improves patient satisfaction but could also significantly improve clinical outcomes. As a result, the effectiveness of the communication processes between hospitalists and patients—and hospitalists and other healthcare providers—at your facility warrant a closer look.

The levels of communication vary based on the needs of each “customer”—whether it is the patient and family, the primary care physician (PCP)/referring physician, or nursing and other inpatient practitioners.

These groups compose the three most important customers with whom hospitalists interact daily, write Jeffrey R. Dichter, MD, FACP, and Leslie E. Cowan, RN, BSN, authors of The Hospitalist Program Management Guide (see editor’s note on p. 9 for more information about this book). Dichter is a previous president of the Society of Hospital Medicine and the director of the hospitalist program at Ball Memorial Hospital in Muncie, IN. Cowan is the patient placement and resource manager at Ball Memorial.

First, determine who your customers are and form appropriate means of communicating with them, advise the authors. They recommend defining customers’ needs and expectations and then building the system around them. For example, find out what your customers want by formally surveying and engaging them in simple discussions.

Second, the authors recommend developing and adhering to a predefined set of procedures and protocols for each customer group. Put these procedures, protocols, and expectations in writing and provide them to all customers and stakeholders.

Mechanisms for requesting hospitalist services

Discussion between hospitalists and other physicians is arguably the most important communication link in a hospitalist program, according to the authors.

Therefore, hospital policy should clearly define how other physicians, physician office staffs, or emergency department (ED) physicians might access the hospitalist service.

When building a communication system, first gather feedback from these physicians. Dichter and Cowan outline the following most commonly employed mechanisms through which other physicians contact hospitalists:

- **The referring physician or office staff pages the hospitalist to inform him or her of the requested admission or consultation.** The advantage of this mechanism is that the hospitalist has an opportunity to speak directly with the referring physician or staff member. The disadvantage is that it requires the office staff to depend on a return call from the hospitalist, thereby risking delayed or missed notification.
- **The referring physician or office staff calls the request to the hospitalist’s office, an admissions coordinator, or his or her administrative equivalent.** This individual is responsible for notifying the hospitalist about the patient whom he or she must see. This mechanism makes it quick and easy for the referring physician to request hospitalist assistance. The downside is that there may be no direct communication between the referring physician or office staff and the hospitalist.
- **The ED directly notifies the on-call hospitalist via pager or telephone.**
- **The referring physician or designee communicates directly with the hospitalist in the case of emergency or urgent requests.** This mechanism is analogous to how an ED would access a hospitalist.

Regardless of which mechanisms are used, it is crucial that the process is communicated to referring physicians, their office staff, ED physicians, page operators, and all other key personnel.

**Tip:** Communication procedures must be reinforced over time because of the typical turnover of personnel in healthcare venues.
Mechanisms for communicating with referring physicians

If a hospitalist needs patient information from a referring physician’s office, there should be a mechanism for requesting it, according to Cowan and Dichter. Such a mechanism might include a formal method for requesting documents (e.g., have administrative personnel call) and a checklist of the types of information needed. Typical office information requests include:

- a recent medical history and physician exam
- a current list of medications and allergies
- recent lab or x-ray reports

**Tip:** Don’t forget to spell out the accepted methods for delivering office information (e.g., fax, e-mail, regular mail, etc.) to hospitalists.

Communication during patient hospitalization

According to Dichter and Cowan, the information that PCPs want to see during a patient’s hospitalization will vary. Knowing their preferences is important when constructing this part of a program’s communication protocol.

Key information that most PCPs want to know is:

- whether significant or unexpected clinical deterioration occurs
- any change in code status
- whether any conflict arises between caregivers and patient or family

These circumstances and others might warrant the PCP’s involvement.

Postdischarge information

In arriving at a procedure for postdischarge communication, it is again important to know what the PCPs want. The authors state that commonly identified discharge information needs include the following:

- **PCP must know when their patients are being discharged and what happened during the hospitalization.** A phone call from the hospitalist is a common way to provide this information.
- **PCPs usually prefer to receive a formal discharge summary.** Most hospitals have discharge summaries dictated and faxed or mailed to the PCP’s office. Ideally, this information will be turned around in short order so the PCP receives it the same day as the discharge. If this timing is not possible, the hospitalist service could prepare a brief, even handwritten discharge summary that could be faxed, e-mailed, or otherwise sent to the PCP’s office that day. Any discharge summary should include a list of the patient’s diagnoses, medications, key diagnostic tests, and any other data the PCP desires.
- **In addition to the required elements, there are other key items to address at discharge.** These include new diagnoses and supporting criteria or data, other diagnostic tests performed, changes in medication regimens, changes in diet and rationale, and carefully outlined discharge plans and follow-up—especially tests such as x-rays and blood tests.
- **If discharge summaries are sent via fax from the hospital, verify that all referring physicians have fax machines and whether/when they turn them off.** It may be worthwhile to keep a log of where and when each discharge is faxed or sent to help verify its receipt.
- **Patients often have difficulty with discharge instructions and plans.** Inform the PCP verbally and note in the discharge summary any key follow-up issues to help optimize patient follow-up and compliance.
- **It’s helpful for hospitalists to make a daily telephone call to PCPs for updates and discharges.** However, due to the nature of hospital work, this may not always be possible.
- **Provide each patient with a copy of his or her own discharge summary, because he or she is apt to bring it along to follow-up appointments.**

Editor’s note: Next month, HMA will focus on improving communication with patients during hospitalization and bettering communication between hospitalists and nursing/other inpatient professionals. To learn more about the book The Hospitalist Program Management Guide, published by HCPro, go to www.hcmarketplace.com/prod-2267.html.
Flu season is nothing to sneeze at
A refresher about hospitalists’ role in immunizing patients

According to the Centers for Disease Control and Prevention (www.cdc.gov/flu/about/qa/disease.htm), the peak of flu season in the United States can occur any time from late December through early March. As a result, it is critical for hospitalists to administer immunizations to patients before the peak.

Hospitals—host to high volumes of patients, families, healthcare practitioners, and employees in close quarters each day—can be prime breeding grounds for influenza. And unlike many other viral respiratory infections, the flu can cause severe illness and life-threatening complications in many people, especially those considered at high risk.

Below, Kenneth G. Simone, DO, founder and president of Hospitalist and Practice Solutions based in Brewer, ME, answers HMA’s questions on hospitalists’ role in vaccinating patients for the flu:

Q: Who should receive the influenza vaccine?  
A: High-risk patients are typically defined as individuals who  
▪ are older than 65 years of age  
▪ have underlying pulmonary disease (e.g., chronic obstructive pulmonary disease), asthma, cystic fibrosis, etc.  
▪ have diabetes or are immunocompromised  
▪ have multiple/severe medical problems  
However, in my opinion, all patients who are hospitalized during the flu season (and during flu immunization season) and who have no allergy to the vaccine, eggs, or feathers should be immunized.

Q: What is the optimal time period this season to vaccinate patients?  
A: From the end of October through December.

Q: What are some tips for helping hospitalists educate patients about getting the vaccine?  
A: Hospitalists should advise patients to receive the flu vaccine to protect themselves, people with whom they come into contact at the hospital, and family members.

Q: What other roles can hospitalists play in immunizing patients?  
A: Hospitalists can take the initiative by offering and ordering a vaccination for all appropriate hospitalized patients (i.e., those with no allergies) during the flu immunization season.

Q: How can hospitalist program directors encourage their own “invincible” staff to get vaccinated?  
A: Directors should advise their medical staff that getting immunized is both their social responsibility and obligation (e.g., so they won’t contract the flu and infect patients/staff in the hospital). Remind them that they must lead by example.

Q: Should hospitals expect shortages of the vaccine this season?  
A: There shouldn’t be, but the major suppliers are slowly releasing them in some regions of the country and thus creating an apparent shortage.

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