Hospitalists are at the forefront of quality improvement (QI) initiatives and usually oversee their implementation, but such projects can be both daunting and time-consuming. So where do you start?

Hospitalists and QI go together like peanut butter and jelly, says Lakshmi Halasyamani, MD, a hospitalist and associate chair of the department of internal medicine at St. Joseph Mercy Hospital in Ypsilanti, MI.

“I have experienced all the ways a [QI] system can make my life more difficult,” says Halasyamani. “But if you are working in a hospital with multiple hospitalist groups, the [group that takes on QI] will be the one at an advantage.”

There are plenty of other reasons to engage in this work, too, she says. Your hospitalist program can increase efficiency and lower costs for starters, but it’s also the right thing to do for patients and can make your job more fun and interesting, she says.

Halasyamani outlined how a hospitalist can put together a QI project that has the best chance of succeeding during her precourse quality seminar before the Society of Hospital Medicine annual meeting in Dallas in May.
QI project  < continued from p. 1

differently by different people, or about something that
needs to be redone, or something that is a hassle,” she
explains. It could be something simple and obvious.
Halasyamani once asked her team to add up the
minutes they spent in a single day looking for charts. The
range was 57–77 minutes. “I don’t think people would
give that time away. They could be using that wasted
effort on something else,” she says. Figuring out how to
limit the time spent searching for files was the basis of
one QI program Halasyamani implemented.

Developing your QI team

QI isn’t about a single person’s ideas, she says. The
team you assemble to tackle a problem has to be mul-
tidisciplinary. Following are some important steps to
remember when establishing your QI team:

1. Include a diverse cross-section of staff
2. Establish and vary the team’s leadership
3. Invite the “naysayers”
4. Control the team’s size
5. Make the meetings effective
6. Establish clear rules, then follow them

Step #1: Include a diverse cross-section of staff

“Broaden your ideas of who you think should be on
a team,” Halasyamani says.

Physicians, nurses, and pharmacists are the obvious
choices. But environmental services, clerks, transport
personnel, kitchen workers, and janitorial staff members
can add something to the discussion.

“They all have different ideas. We are talking about
adding patients to one of our teams. It’s scary, but we are
doing it,” she says.

Step #2: Establish and vary the team’s leadership

The team leader is the person who schedules and
chairs the meetings, sets the agenda and ensures that it
is printed for each meeting, records team activities, and
reports to management. This is the person who ensures
that the team is moving toward its goal and that meetings
are more than a chance to eat while sitting down.

“People look to the leader as the person who will say
something first. You want him or her to be a coach who
will encourage participation,” Halasyamani notes.

The facilitator is like the den mother—he or she makes
sure that everyone follows the rules, that everyone who
wants to speak gets the chance to do so, and that no one
person dominates the conversation, she says. The facilita-
tor assists the team leader and identifies areas of potential
conflict—both within meetings and outside of them.

A QI team shouldn’t be hierarchical, Halasyamani
advises. That means it shouldn’t always have the doctor

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at the top. Team leadership rotates in her facility. “There is no one team leader forever in a QI program. Your time on stage is limited,” Halasyamani notes.

She also advises leaving last names and titles at the door. That helps to ensure that kitchen staff members will mention their ideas with the same confidence that clinical pharmacists do.

**Step #3: Invite the ‘naysayers’**

Halasyamani recommends bringing people into the team who might not like the idea you are working on. “They’ll try to ruin it anyway,” she says. “This way, you can work with the naysayers from the start to find out what they absolutely can’t live with, eliminate it from your program, and build a consensus.”

**Step #4: Control the team’s size**

Although good representation on a team is important, Halasyamani says teams shouldn’t get too big. “The people who want to be there should be there, but you have to be clear on your expectations. Tell them what they will have to do. Usually that will weed out all the others. You have to have people who will come to the meetings prepared and do the work that needs being done. Usually, that’s between eight and 15 people,” she says.

*Note:* If someone asks to be on the team, always say yes, Halasyamani adds, as the chances of finding more than 15 people who want to do the actual work of a QI project are probably limited, anyway.

**Step #5: Make the meetings effective**

When Halasyamani asks her peers to talk about good teams they’ve been on, they all talk about Little League or high-school sports teams. “It’s never anything to do with medicine,” she says.

Committees are a different story. Physicians can talk at length about their committees. But a team is different—it requires an open environment in which consensus is sought. The meetings have to be effective and move toward a goal.

**Step #6: Establish the rules, then follow them**

Many people roll their eyes when Halasyamani mentions following rules, but she says rules are the backbone of a successful QI program.

“You have to lay out in writing the expectations of members, what kind of communication you will have, what time the meetings start,” she says.

She mentions that people used to be routinely late to meetings at St. Joseph.

“They started at ten past the hour, so everyone would come in at a quarter past. Now, we start on time and people come running into our meetings. They know if they are late, they will miss critically important things,” Halasyamani says.

Expectations for team meetings must be written down and should include the following:

- Attendance by members must be regular
- All ideas must be considered equally
- All participants should be able to speak freely
- Participants must speak in turn
- Participants should attack problems, not people
- Meetings must start and end on time
- All agreements must be kept unless renegotiated
- A consensus must be reached
- All participants must speak with one voice (i.e., there should be no mention of in-meeting disagreements; once you come to an agreement, don’t speak out against the idea)
- Silence equals agreement

**Implementing your QI program**

After you build your team, there are several other steps you can take to get your QI program up and running.

Define your goals: Every project should have clear aims, measures, goals to implement, and a way to test for success. The aim should be something you can put into an obvious statement. Halasyamani uses the mnemonic SMART to describe the characteristics of a good aim statement:

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QI project < continued from p. 3

➤ Specific
➤ Measurable
➤ Aggressive yet achievable
➤ Relevant
➤ Time-bound

A sample of a good aim statement for venous thromboembolism (VTE) prevention might be:
➤ Within the next six months, 95% of patients will be on a VTE prophylaxis regiment appropriate for their level of VTE risk, as defined by our protocol
➤ Within 12 months, we will halve the number of hospital-acquired VTE in our institution

Identify your measuring sticks: Your measurements have to be quantitative, and you need to identify the data you are going to collect.

“If it’s not directly linked to your aim statement, it’s not likely to be any good,” she says.

It doesn’t have to be complicated, either. If you are only looking at three data points, that might be fine.

“Having a low number of metrics is not a good enough reason to increase the data you collect. Just do the critical ones, and do the least amount of hand collection as possible,” she says.

Find good data sources. There are plenty of sources for data, including:
➤ Clinical data: Electronic medical record reviews and chart reviews are good sources. If you are including chart reviews, Halasyamani says to make sure you have a good sampling process so you don’t have to go through a year’s worth of charts by hand.
➤ Administrative data: Look at your hospital’s existing data repository—what it submits to external sources, such as payers and regulators. Your pharmacy computer system is another good resource.
➤ Provider and patient surveys: “With tools like Survey Monkey and Zoomerang, you can reach a lot of people quickly,” Halasyamani says.

➤ Direct observation of care: Whatever you choose to measure, make sure it’s something that you can collect quickly.

“If you can’t establish a baseline quickly, you will lose your team—even if you provide lunch,” says Halasyamani.

Don’t just look at outcome-based data, such as mortality, complications, cost, and length of stay, she advises.

“If you only look at [outcome-based data], you may not understand what leads to improvement or decline. You have to look at outcome measures and look at what part of the process is working and what is failing. Quality has to be measured in terms of structures we work in, the processes leading to outcomes, and outcomes,” says Halasyamani.

Consider the following alternative measurements:
➤ Process measures. These include measuring a component of the encounter between provider and patient, such as whether an order set was activated or a sticker was used on a chart.
➤ Structure measures. These look at human and material resources or organizational structures such as provider characteristics (e.g., specialty or experience), patient characteristics (e.g., comorbidities), delivery system characteristics (e.g., whether it is a hospital or clinic), or what the specialty mix is at that location.
➤ Balancing measures. These include whether the changes designed to improve one part of the system cause new problems in other parts, such as whether an intervention to reduce length of stay raises readmission rates and mortality.

Lastly, Halasyamani advises that when you start a QI project, make sure it is sustainable. “We say that a pilot project is the kiss of death,” she says. “You have to move to a program that is more than that—that is sustainable and long-lasting.”
If malpractice isn’t on your radar, it should be  
Managing risk helps hospitalists protect their patients—and their programs

As a young specialty, hospital medicine hasn’t had the same exposure to malpractice issues, for better or for worse, that specialties such as obstetrics or neurosurgery have had.

However, the prospect of litigation involving hospitalists is a reality, and one that will likely increase, says Peter Behnke, a broker at Healthcare Risk Specialists, a professional liability insurance brokerage in West Hartford, CT.

Why? Hospitalists work in the riskiest environment there is in healthcare—hospitals, Behnke says. They care for increasingly ill patients for whom a single mistake can have dire—or even deadly—consequences.

But hospitalists are a step ahead of other specialists in one respect, says Behnke: The hospitalist business model is built on patient safety and quality of care—two things that risk managers like to emphasize.

“One thing hospitalist groups can use to differentiate themselves in the market is their risk management, their protocols, and their processes that help keep patients safe,” Behnke says.

The burden of proof

In malpractice cases, the plaintiff has to prove four things by a “preponderance of evidence”—a standard that translates into “more likely than not,” said Allen Kachalia, MD, JD, a hospitalist at Brigham and Women’s Hospital in Boston, during a seminar on malpractice and risk management at the recent Society of Hospital Medicine meeting in Dallas in May.

The plaintiff must prove that:

► There was proximate causation. That means that the physician named in the suit did something that was the proximate cause of the damage.

Malpractice history

The first modern claims of medical malpractice were in the 1970s, said Kachalia.

In the 1980s, there was a crisis of affordability, but because there was a fee-for-service environment, physicians were able to adjust their fees to compensate.

In the 1990s, there was another up-tick in malpractice. Premiums went up astronomically. In some states, physicians in certain specialties were having trouble affording insurance. Some doctors stopped practicing, some started to go without coverage, and others asked for government intervention. And many physicians—if not most—started practicing defensive medicine, he said.

There is disagreement about why malpractice rates went up so much in the past decade. Some argue that the insurance companies were merely recouping their losses from bad investments. If you look at the data, Kachalia said, you can argue about the preponderance of suits from either side.

A Harvard Medical Practice study looked at 30,000 medical records for negligent adverse events. The researchers found that 1% of all discharges had one such event. They took those cases of negligence and looked at how many of them led to claims. Of the 27,177 negligent adverse events in 1984, there were only 3,675 claims—a ratio of 7.4 to one.

A subsequent study in Colorado in 1992 showed a ratio of 5.7 to one, and in Utah, in the same year, a ratio of four to one.

“If you look at those who are suing, only one in six times did they find negligence underlying that care,” said Kachalia. “But only 2% of the time are patients getting ‘justice’ for their adverse events.”

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Malpractice < continued from p. 5

Last year, the New England Journal of Medicine reviewed 1,500 claims in a study that aimed to determine the factors that led to claims. They found the following:

➤ In 97% of the claims, there was an actual injury
➤ In the cases with injury, 63% had an error, although not necessarily a negligent error
➤ In 40% of the cases, there was no evidence of error
➤ In cases in which there was an error, 27% of the time there was no payment
➤ In cases in which there was no error, 28% of the time there was payment

“You could write the headline two ways,” said Kachalia. “That frivolous litigation isn’t as prevalent as we thought, or that 40% of all malpractice suits are groundless.”

Reducing malpractice risks

Mark Hall, JD, a professor of law at Wake Forest University in Winston-Salem, NC, who has written about malpractice and hospitalists, says hospitalists need to be particularly concerned about managing patient handoffs to other physicians.

“You have to make sure that [the handoff] is done with proper communication and documentation,” he says. Peer-reviewed literature shows a strong correlation between patient dissatisfaction and litigation, said Kachalia.

Consider the following:

➤ A 1997 study in the Journal of the American Medical Association (JAMA) found that primary care physicians with no claims against them have longer visits with patients, use more humor, and provide more information to, and elicit more information from, their patients.

➤ A 1994 study in the Archives of Internal Medicine (AIM) found that in 71% of malpractice cases, the plaintiffs reported that they didn’t like their physician, sensed a cover-up, or merely wanted to know what happened.

Sample case scenario for a risk-management discussion

A 72-year-old white male goes to the emergency department (ED) on Wednesday and is experiencing shortness of breath. The ED staff determines that the patient is suffering from either pneumonia, heart failure, or both. It starts antibiotics, draws cultures, and admits the patient to the hospitalist service.

The hospitalist on duty diagnoses the case as heart failure and stops the antibiotics because the chest film doesn’t show signs of pneumonia. The primary care physician (PCP) and the patient’s cardiologist visit on Thursday and Friday. The patient slowly improves. The first hospitalist signs the patient out to the hospitalist covering on the weekend. On Sunday afternoon, the patient has a fever. The x-ray looks clear, the white blood count is about 12,000, and a blood culture is taken on verbal orders. The patient looks well, and only one dose of antibiotics is given, pending results of the culture.

During the patient handoff on Monday, the original hospitalist is not told about the fever or antibiotics. The patient looks good and wants to go home. The hospitalist discharges him. The cardiologist and the PCP tell the hospitalist they will follow up and see the patient during the week. On Wednesday, the patient is back in the ED with shortness of breath, fever, and hypotension. He goes to the ICU, where he needs intubation for a day and pressors. He is transferred back to the hospitalist service, where the first hospitalist looks through the chart and notices that the cultures drawn on Sunday had turned positive postdischarge. The hospitalist then tailors the therapy and thinks that the patient will make a full recovery. He sends the patient home with a PICC line. The patient and family thank the hospitalist for all his work. Consider these questions:

➤ Was there an error?
➤ Was the care negligent?
➤ Do you need to tell the family?
➤ Will it lead to litigation?
➤ If so, who will be sued?

Source: Allen Kachalia, MD, JD, Brigham and Women’s Hospital in Boston.
A 2002 study in *JAMA* reported that physicians with more complaints against them are more likely to have more suits.

“Relationship matters,” Kachalia said. “We don’t have the advantages of a long-term relationship with a patient. Often, they don’t even want to talk to us until they know their PCP says it’s okay. Trust doesn’t come right away.”

The best defense is to make sure you work to eliminate errors in care. That may not prevent litigation, he said, but it can help to reduce the number of successful claims. Certainly, hospitalists are seen as having expertise in quality and safety improvement. They should continue to take the lead in this area, Kachalia said.

“The focus has to be on reducing preventable injury and maintaining good relationships,” he noted.

### Does acknowledging errors help?

Many patients simply want to know what happened when something goes wrong with their care, and seek an acknowledgement of their injury or the error, said Kachalia.

There are 28 states with “I’m sorry” laws that allow a physician to apologize to a patient for his or her injury but prevent a plaintiff from using that apology against the physician in any future claim. However, it’s not yet known whether or not apologies actually reduce claims.

In some states and organizations, acknowledging errors is mandatory. In Pennsylvania, for example, state law requires hospitals to disclose errors to patients in writing. Five other states have similar legislation, said Kachalia. Some institutions—most notably the Boston-based Dana Farber Cancer Institute—have instituted policies that require staff members to tell patients about errors and apologize for them, he noted.

Still, it’s hard to determine whether apologizing leads to fewer malpractice lawsuits, or whether patients are more likely to file a lawsuit because they know there was an error. It’s similarly hard to know whether patients are more likely to sue if they find out that a hospital or physician tried to avoid disclosing an error, Kachalia said. But, he added, in a survey of families who sued after perinatal injuries, 25% of them say they did so due to a lack of complete honesty by the hospital and/or physician.

Some facilities now acknowledge errors and offer to pay for any injury up front. This option is attractive to some organizations because paying for the injury may mean spending a lot less than they would in any subsequent litigation, said Kachalia. The University of Michigan in Ann Arbor started this policy in 2002.

The bottom line is that patients want to know about every error, even the minor ones, according to an *AIM* study in 1996.

Later, a 2004 *AIM* study found that 66% of the time patients want compensation for the mistakes, and 40% of the time they want some sort of discipline for the doctor who made the error.

### Don’t acknowledge mistakes alone

If you decide to acknowledge a mistake, don’t go it alone, Kachalia advised. Get risk management, your insurer, social workers, patient relations staff members, and chaplains involved. They have expertise that you don’t. Further, be aware of your hospital’s disclosure policy. “Don’t wing it. It’s not worth it,” he said.

When you talk to the patient, communicate clearly, be sincere and honest, state the facts, and don’t lay the blame anywhere. Tell the patient that all of the facts will be gathered and that you are sorry for the bad outcome. In the meantime, “Assure them you will take steps to ensure this doesn’t happen in the future. And document all your discussions,” Kachalia said.

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Study: Hospitalists deliver lower lengths of stay, costs
But after 10 years, do we know anything more about quality measures?

There have been plenty of studies showing that hospitalists can deliver lower lengths of stay and costs per case for the patients they care for.

But, for the first time, a new study shows evidence of the same benefits when comparing hospitalists’ care to that of general internists and family practitioners across multiple facilities.

Peter Lindenauer, MD, a hospitalist at Baystate Medical Center in Springfield, MA, said that he and his colleagues looked across multiple hospital sites and at the difference in costs, length of stay, readmissions, and mortality rates between hospitalists, general internists, and family practitioners at those multiple centers—a focus that other studies have not touched on.

They presented those findings during May’s annual Society of Hospital Medicine conference in Dallas.

“To date, studies have found benefits on costs and length of stay, but no difference in readmissions,” he said. “There might be a potential benefit on mortality rates, but most of the studies were done at a single academic hospital. We wanted to compare hospitalists, general internists, and family physicians, and we wanted to see if there was any difference in outcomes based on the volume of patients they have as has been seen in surgical studies.”

Study parameters

Lindenauer and his peers did a retrospective cohort study of patients in 45 hospitals, covering nearly 77,000 patients who were treated by 284 hospitalists, 993 internists, and 971 family doctors.

The patients all had one of the following seven diagnoses:

- Pneumonia
- Heart failure
- Chest pain
- Ischemic stroke
- Urinary tract infection
- Acute myocardial infarction
- Acute exacerbation of chronic obstructive pulmonary disease

The following factors were observed for all patients in the study:

- Length of stay
- Cost per case
- Inpatient mortality
- 14-day readmission rate

The findings were also adjusted for age, gender, ethnicity, diagnosis, comorbidities, size of hospital, whether it was an urban or rural facility, whether it was a teaching hospital, its location, and physician factors, such as annual case volume.

What the study found

Hospitalists were more likely to take care of patients who were younger, and their patients were more likely to be black or Hispanic.

Hospitalists also treated more patients with each of the seven conditions—about 70 patients per year, compared with 30 for general internists and 20 for family physicians.

In comparison to internists, hospitalists’ patients’ lengths of stay were an average of 0.6 days less, and their costs were $400 less.

With family physicians, the comparison showed that

“We wanted to compare hospitalists, general internists, and family physicians, and we wanted to see if there was any difference in outcomes based on the volume of patients they have as has been seen in surgical studies.”

—Peter Lindenauer, MD
length of stay among patients cared for by a hospitalist was 0.4 days shorter, and costs were similar.

There was no significant difference in mortality or readmission rates.

Lindenauer’s group also looked at high-volume general internists and family physicians to see whether there was any significant difference there, but they found only modest attenuation or no change, he said.

**Study limitations**

There were limitations to the study, Lindenauer noted, including the following:

➤ It was observational
➤ It focused only on seven conditions
➤ It looked only at inpatient mortality
➤ Some practitioners may have been misclassified as hospitalists by their hospitals

Additionally, the study did not include data regarding how long the physicians had practiced or any financial incentives they may have had that might have affected their behavior.

**Analyzing the results**

Lindenauer said he can’t explain the disconnect the study shows between family physicians and hospitalists. Family physicians’ patients had higher lengths of stay but similar costs to hospitalists’.

Lindenauer said it may be because of reduced redundancy in test ordering, or because hospitalists know the patient in both the inpatient and outpatient setting and, therefore, are less likely to work up a patient as intensely as a physician who is not as familiar with him or her.

And what about the continued lack of evidence regarding whether hospitalists provide better quality of care than their counterparts?

“Our hypothesis going into the study was that hospitalists would improve efficiency without adversely effecting mortality or readmission, since a key question is whether efficiency can be safely improved,” Lindenauer said.

“Inpatient mortality and readmission are very, very rough measures—which may better reflect safety rather than quality,” he said.

One should also keep in mind that there are actually very few quality improvement interventions that have been shown to positively affect readmission rates and mortality, Lindenauer continued.

“For example, while there is a great deal of enthusiasm for improving adherence to things like beta blockers and aspirin for patients with acute myocardial infarction, investigators have had a difficult time demonstrating a link between improvements in adherence and improvements in outcome,” he said. “Additional research is needed to better understand the link between hospitalists and quality of care.”

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The Phoenix Group gets ready to take on the issues

Private practice group forms to push hospitalist issues forward

Adam Singer, MD, the CEO of IPC—The Hospitalist Company, simply wants his voice—and the voices of other hospitalists—to be heard.

Singer created The Phoenix Group in an effort to ensure that he and his peers in the world of private hospitalist groups have a forum to share their ideas.

Together, the 13 people who met during the group’s first meeting in March employ 10% of all practicing hospitalists in the United States (for a complete list of the original participants, see “Phoenix Group participants” on p. 11).

If you count the people they’ve taught and trained, Singer says, it’s even more.

Singer insists that this new group isn’t just about talking shop, but represents a group of people who are committed to addressing the needs and issues facing hospitalists today.

“The first meeting blew my mind,” he says. “It was way more than I expected. We found commonality among us and agreement of the things we want to see done and who we [need to start a dialogue] with to get that done,” says Singer.

Tackling pertinent issues

High on the new group’s priority list is staffing shortages and related immigration issues.

“Hospital politics, visa caps, and a massive shortage of medical providers are all combining to make immigration issues and the use of foreign medical graduates important to hospital medicine,” he says.

Another issue the group has discussed is exclusive contracting and the related issue of exclusive privileging.

“There is a big difference between the two that a hospital might not see,” Singer says. “Some hospitals would like to have exclusive contracts and throw everyone else off the medical staff.”

The group has also created a white paper detailing the issues it covered during its first meeting. These topics include the following:

✔ Physician supply and demand. After discussing the scarcity of internists in both the inpatient and outpatient settings, the group talked about the issues exacerbating the shortage, include scheduling issues and training that isn’t focused on hospital medicine.

Among the strategies the group members discussed for addressing the problem are the following:

➤ Tapping into the pool of family practitioners and luring them to hospital medicine
➤ Changing visa laws so that a greater number of foreign medical graduates can work in the United States
➤ Better and greater use of midlevel practitioners
➤ Faster issuance of licenses
➤ Working to attract more internists to hospital medicine
➤ Making better and more efficient use of existing hospitalists

✔ Revenue-related issues. If there are too few practitioners, you can’t grow your practice, and when there is a shortage of physicians, the cost of hiring the few who are available is much higher.

Add increasing malpractice costs, the cost of IT, and the ever-present threat of decreasing reimbursement, and you have the makings of fiscal crisis.

The group suggests several potential solutions, including reducing variable costs, securing longer-term contracts, and better hospitalist compensation surveys so that groups know what they should be paying their physicians.

✔ Pay for performance (P4P) and gainsharing. The government regulates what behaviors can and cannot be rewarded, and it often prohibits rewarding the very behaviors that hospitalists strive to achieve, such as lower length of stay. P4P is great, but the current Medicare program is small, according to the white paper.
The Phoenix Group members suggest the following:

➤ Working with regulators to create P4P programs that relate specifically to hospital medicine
➤ Putting systems in place that will measure the things that hospitalists do best, such as improving patient satisfaction, clinical communications, and continuity of care
➤ Reporting P4P core measures to the relevant bodies sooner rather than later

✔ **Hospitalist turnover and dissatisfaction.** Bad work environments, too few hospitalists trying to do the work of growing programs, bidding wars for existing hospitalist that lead to unsustainable expenses, and unenforceable noncompete contract clauses all lead hospitalists to hop around from job to job.

The group came up with several potential solutions, including better outreach to residency programs, clearer understanding of the core competencies of hospital medicine, and writing articles on how education and training of hospitalists should change.

✔ **Practical training of hospitalists.** Hospitalists lack education in several key areas, according to the white paper. Better practice management skills (e.g., in areas such as coding, revenue cycle management, case mix indices, and malpractice) are necessary for a hospitalist to succeed.

The group suggests creating training materials that address these issues; recommending that the Society of Hospital Medicine (SHM) include these areas more in its education efforts; and expanding SHM speakers to include more people with expertise in these areas.

✔ **The future of the Phoenix Group.** The group also looked at issues that should be discussed in the future, including the value of hospital medicine, clinical care models, practice management issues, risk management and malpractice, benchmarking, and legislative advocacy.

Singer says the Phoenix Group represents hospitalists in almost every state in the union.

He hopes the group will grow, but not by much.

“We want to keep it small and relevant. I think if you get more than 20 people, it gets unwieldy and it becomes more of a lecture than a discussion group,” he says.

Singer also thinks the unified voices of the group will eventually help set the agenda for hospital medicine in the future.

“There are important people in the hospitalist industry, and I think that they will have an impact. We didn’t think that the society was paying attention before we got together. I think they will now. It’s not that we felt there was a lack of access. But when we say something together as one voice, we can agitate more effectively,” he says.

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Phoenix Group participants

➤ Ron Greeno, MD—Chief Medical Officer, Cogent Healthcare
➤ Michael Gregory, MD—CEO, Apogee Medical
➤ Steven Houff, MD—CEO, Hospitalists Management Group
➤ Kirk Matthews—CEO, Inpatient Management, Inc.
➤ Krishan Nagda, MD—CEO, Central Florida Inpatient Medicine
➤ Sandy Peterson, PhD—CEO, Hospital Inpatient Management Services
➤ Robert Reynolds, MD—CEO, PrimeDoc, Inc.
➤ Marium Steele, MD—CEO, Texas Inpatient, PA
➤ Darren Swenson, MD—CEO, Total Care Management Associates
➤ Michael Wagner, MD—CEO, EmCare Hospitalist Division
➤ George Wilcox, MD—CEO, ADMIT
➤ Robert Young, MD—CEO, Eagle Hospital Physicians
Looking at common hurdles that hospitalists face

In his varied career as a primary care physician, the administrator of a hospitalist program, and a consultant working to establish and revamp hospitalist programs around the country, Ken Simone, DO, of Hospitalist and Practice Solutions in Brewer, ME, says that he has been able to put common problems hospitalists confront into three main categories: teamwork, effective communication, and working in integrated healthcare delivery systems. Almost every common obstacle that a hospitalist program will face can fit into one of those areas.

Simone’s newly released book Hospitalist Case Studies: Tactics and Strategies for 10 Common Hurdles was designed to help hospitalists overcome those pitfalls.

“I’ve observed these problems around the country,” says Simone, a member of the Hospitalist Management Advisor editorial advisory board. “I saw them in multiple practices as a consultant, as a hospitalist administrator asked to fix the problems, and as a primary care physician using multiple hospitalist programs both good and bad.”

By addressing the problems that relate to these three themes and using applicable case studies, Simone felt he could help hospitalists, administrators, nurses, and case managers work through their problems systematically.

Along with the case studies, the book discusses the different points of view that arise from these conflicts. Simone says he didn’t want to take a position on who was right or wrong in a particular situation even though, at times, it can be obvious. But, says Simone, even in those cases in which someone is wrong, it is important to understand his or her point of view.

There are also “points to ponder,” sample worksheets, and suggestions for tools to use in solving each problem. The chapters cover issues such as difficult patients, incompetent doctors, patient dumping, and conflict management. “I wanted it to be reader friendly and understandable for all readers. I wanted to include brief cases as the vehicle for the message—to promote discussion and drive the creative spirit,” Simone says.

“The way you apply these lessons to your own program, the way you customize it is part of the art of medicine,” he adds. “It isn’t the answer, it is an answer.”

Editor’s note: Hospitalist Case Studies: Tactics and Strategies for 10 Common Hurdles, by Ken Simone, DO, is available from HCPro, Inc., and can be ordered through www.hcmarketplace.com.

Does this sound familiar?

The following is a sample case study and “points to ponder” from Hospitalist Case Studies: Tactics and Strategies for 10 Common Hurdles by Ken Simone, DO:

Case study

Mr. Wasinski, a 64-year-old patient, presents to the emergency department (ED) at 7:30 a.m. with chest pressure radiating to his left arm and shortness of breath. His medical history is significant for angina, hyperlipidemia, hypertension, cervical degenerative disc disease, and tobacco abuse. Dr. Lybal, the ED provider, eyeballs the patient, orders an EKG and appropriate blood work to rule in or out an acute myocardial infarction (MI), and pages the hospitalist provider to evaluate the patient.

Dr. Duncan, the hospitalist, requests a callback after the workup is completed. He is appalled that he was contacted so early in the process. Dr. Lybal couldn’t even provide him with the findings of the physical exam because it hadn’t been done yet. Dr. Lybal is infuriated that the hospitalist refuses to immediately evaluate the patient. The patient clearly needs admission either for acute MI or unstable angina.

Points to ponder

➤ Would Dr. Lybal have deferred his evaluation to the PCP in the absence of an on-site hospitalist provider?
➤ Why did Dr. Duncan hesitate to evaluate the patient as soon as possible when the patient presented with such significant risk factors and history?