

Hospitalist Management Advisor

Promote program success

Educate PCPs, staff, and the public about your hospitalists

Hospitalist programs are still so new that some organizations haven't quite figured out how to incorporate them into the clinical setting, let alone devise a plan to market these services to others.

But according to **Ron Greeno, MD, FCCP**, founder and chief medical officer of The Cogent Group based in Irvine, CA, it is important for organizations to avoid short-sightedness when it comes to their hospitalist programs. Don't just focus on the benefits your program provides to your facility—consider the value it brings to the competitive market, as well.

"I encourage hospitals to position the [hospitalist program] as a service line to differentiate themselves from their competitors. It's relatively easy to do," says Greeno.



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Creating a successful hospitalist program is no easy task, and neither is staffing it. If physicians are scarce, you might consider utilizing midlevel practitioners.

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If you do decide to incorporate midlevel practitioners into your program, you'll need a road map. That's where Hospitalist Management Resources' guidelines can help.

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Physician satisfaction is the key to retention, but do you know how to keep your hospitalists happy? It takes both a long- and short-term approach.

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You can't have a successful hospitalist program if there isn't anyone at the head table looking out for its interests. But first, you have to find out whether anyone wants the job.

Alert area PCPs to your presence

Hospitalist programs can function in relative obscurity, so it's important for administrators to educate the members of their own medical staff and the patients their hospitals serve about the benefits of the program.

But if administrators are looking for a financial boost and a return on the initial investment, Greeno says, a campaign aimed at educating area primary care physicians (PCP) about the presence and convenience of your hospitalist program can be a jackpot.

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—Ron Greeno, MD, FCCP

tient tests and other services, it brings about \$1 million in revenue to the hospital," says Greeno.

More and more often, PCPs don't want to go to the hospital to perform the services that hospitalist provide, and if hospitals can convince PCPs that their patients achieve better outcomes when hospitalists care for them, it's a win-win for everyone involved.

"The hospitals that really look at it this way are way ahead of everyone else," Greeno says.

The two keys, according to Greeno, are designing your hospitalist program as a service line (e.g., cardiology, neurosurgery, etc.) and selling this "high-quality program" as a service to the community.

"[Such efforts] can attract new patients to the hospital and new referrals," says Greeno. "It's a marketing effort by the hospital, but one the hospitalists can support. It creates a lot of benefit. But it's a responsibility of the hospital to take that on as a marketing project."

Hospitalists

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Tip: A simple and proactive strategy is to draw up a fact sheet that details the benefits of the hospitalist program and deliver it to area physicians' offices.

Capitalize on exposure

Greeno expects that in the future, a typical hospitalist program will care for as much as 80% of the patients that come through an average emergency department. Such productivity will in turn lead the way for larger marketing campaigns, such as radio spots or billboard advertisements.

"Right now, it will serve hospitals well to educate the broader medical community about the quality of the hospitalist program," Greeno says.

Because most hospitals haven't started doing this yet, it's an easier task for hospitals committed to the initiative.

"Every hospital in town says they have the best cardiac surgery program," says Greeno. "But right now, most of the hospitalist programs aren't that great. So if you're willing to do it right, you can create a hospitalist program that is significantly better than your competition."

Those organizations that beat their competitors to the punch not only get a leg up in building a better program, but also they can lay claim to having a superior program.

"If I was a hospital, I'd be all over this," says Greeno. "It's the wave of the future, so get there first."

Educate staff members

For years, hospitals had house doctors or moonlighters. They weren't necessarily highly qualified practitioners, and as a result, they weren't always respected by their peers.

With the advent of hospitalist programs, these physicians are better trained, organized, and respected. But in many cases, medical staffs don't realize it's a specialty service.

"I've personally given talks at hospitals, and people are surprised at the growth of the specialty," Greeno says. "They had no idea what it's there for, and they misinterpret who those doctors are. And now, knowing this, they start treating [the hospitalists] as equals."

Educating your staff members about your hospitalist program is crucial to promote:

- Hospitalist satisfaction
- Clinical productivity
- Customer service

Such education should come from the chief medical officer, or some other authority figure with a clinical background, says Greeno. The chief of nursing can be invaluable to you in such an endeavor. "More than any other department, [nurses] see the advantage of having hospitalists," Greeno says. "When they have a problem

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with a patient and they can't get a physician to respond, that's a horrible thing to happen to a nurse. [The nursing department] has great credibility in these matters."

Greeno says grand rounds are a great format to educate medical staff members, as are hospital newsletters. "There are sections in every hospital newsletter to educate their medical staff on different initiatives," Greeno says. "The formats are there; it's just that someone has to take the trouble to educate [the staff members]."

Regardless of the medium, hospitals must be thorough in their efforts to make sure they reach every staff member. "A lot of physicians don't read the literature unless it's in their own specialty. They don't have the opportunity to hear what's going on in other fields," says Greeno.

Persevere with the public

Although the avenues are there to educate your medical staff members, the same can't be said for the public at large. But it's still important to make an effort to introduce the hospitalist staff to your current and potential customers.

When patients are being admitted, they are particularly susceptible to negative experiences, so such education is critical, says Greeno. "Any surprise, especially an unsettling one, is not a good thing."

PCPs who elect to turn their patients over to the hospitalists should educate their patients about the program. "Otherwise, it could be mistaken for not caring about their patients and just dumping them off, when it's just the opposite," Greeno says. "They are looking for a better way to take care of them."

Patients don't mind who cares for them, Greeno says. In fact, he adds, if they are told that specialists are caring for them, it shows them that the hospital takes their medical concerns seriously.

Although you can hope PCPs do the educating, it's also a good idea for your organization to cover itself by creating brochures for patients and providing information on the hospital's Web site for prospective customers. A sample leaflet that Cogent Healthcare provides to patients describing its hospitalist program appears on p. 4. ■

Solicit feedback

Spending time and resources to facilitate patients' understanding of your hospitalist program is only one facet of promoting a successful program. You should also be certain to solicit patient feedback whenever you have the chance. Consider a brief survey with some of the following questions:

- Did the hospitalist spend adequate time with you?
- Did the hospitalist display adequate concern for your condition/treatment?
- Was there sufficient time to ask the hospitalist questions and relay any worries?
- Did the hospitalist keep you informed throughout your hospital stay?
- Was the hospitalist courteous and considerate?
- Were you satisfied with the hospitalist's manner of communication?
- Was the hospitalist available to meet with family members?

You can format questions as yes or no, or provide a rating scale (e.g., poor to excellent) and a space for additional comments.

Communicate openly

For patient feedback to be effective, you must communicate it clearly and openly to your hospitalists and all the other members of the healthcare team. Most importantly, you should share the indicators your facility chooses to measure patient satisfaction.

When hospitalists know what skills their organization is specifically measuring, they are more likely to focus even more attention on improving those skills. That, in turn, benefits the patient and his or her impression of the hospital stay, as well your program; a true win-win situation for all parties.

Remember, for a successful measurement of patient satisfaction, you should consider how the information you collect will affect your program. Notably, you must ask questions that allow you to understand and act on feedback.

For more tips, check out *Tools and Strategies for an Effective Hospitalist Program*, published by HCPro, Inc.

Sample hospitalist program overview

The following is part of a handout that Cogent Healthcare at St. Luke's Hospital in Cedar Rapids, IA, gives to patients to explain its hospitalist program and to answer FAQs.

Cogent Healthcare has established a team of highly qualified, experienced physicians, known as hospitalists, who specialize in caring for patients while they are in the hospital. Our team of hospitalists and nurse practitioners work in partnership with your referring physician and are supported by nurse Clinical Care Coordinators (CCCs).

how does it work?

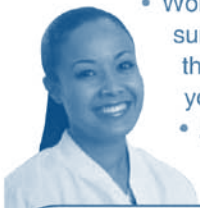
The Hospitalist Care Team will be there for you throughout your stay. During your stay, they will:

- Assess and treat your medical condition.
- Keep your referring physician informed of your progress.
- Coordinate your hospital care including all diagnostic tests such as x-rays, blood tests, or other exams.
- Arrange any specialty care, therapy, or consultations with other specialists.
- Transition your medical care back to your primary care physician when you are ready to be discharged.
- Contact you after you are discharged home to assure that all aspects of your follow-up care plan are in place. If you do not want us to contact you, please let your hospitalist physician or CCC know.

your clinical care coordinator

While hospitalists and nurse practitioners cover your clinical needs, your CCC plays a key role in your care. Your CCC will:

- Ensure that all information needed by the hospitalist physician is available.
- Contact your primary care physician to gather information about your medical history as needed.
 - Work with you and your family to ensure you understand what is happening throughout your hospital stay and allow you to participate in your care.
 - Assist with coordinating your discharge plan and follow-up care.



Why isn't my other doctor here?

Your physician continues to be interested in your well-being and is available for phone consultation. With more medical care moving to the outpatient setting, there are more and more demands on physicians in their office practices. By using a dedicated team of hospital-based physicians and nurse practitioners who focus on inpatient care, the delivery of inpatient care is enhanced.

How will my doctor know what is happening during my stay in the hospital?

Your doctor is fully aware of the fact you are here and has requested the services of the hospitalists to care for his or her patients who need to be hospitalized. The physician is notified upon your admission and will be kept abreast of any significant changes that occur while you are with us. Once you are discharged, your doctor is notified and details of your hospitalization will be communicated in writing. Every effort is made to assure a smooth transition to your primary care physician.

Who will see me after discharge?

Cogent will arrange for your follow-up appointment. You will be seen by your primary care physician or sub-specialist after you are discharged. If you do not have a primary care physician, Cogent will arrange follow-up care from their resources of primary care physicians in the local community.

what our patients are saying . . .

"During my stay, the care team was always by my side, so I knew I was in good hands."

-Former patient

"I had a seamless transition into the care of the hospitalists and back to my primary doctor."

-Former patient

Source: Cogent Healthcare at St. Luke's Hospital, Cedar Rapids, IA. Reprinted with permission.

Consider midlevel providers to ease understaffing pains

Staffing difficulties continue to plague hospitals across the country, and hospitalist programs aren't immune. Rising salaries and a lack of available physicians can make it seem almost impossible to hire and maintain a full staff in many locations.

However, hospitalist programs that are open to change and exploring other options can fill many of those staffing voids with midlevel providers such as nurse practitioners (NP) and physician assistants (PA).

Although it's not as simple as just going out and hiring PAs and NPs, adding midlevel providers to a hospitalist program is something 16%–20% of hospitals are already doing, according to the Society of Hospital Medicine.

"The whole concept of using midlevel providers really started to evolve over the last couple of years," says **Roger Heroux, MHA, PhD, CHE**, partner at Hospitalist Management Resources, LLC, a consulting firm in Colorado Springs, CO. "It can be so difficult to recruit physicians, and adding one midlevel provider can make all your current physicians more productive."

For example, Heroux says, if a hospitalist typically sees 15 patients per day, adding one PA or NP can boost productivity to about 25 patients per day. Although adding a midlevel provider won't necessarily increase productivity to the same degree that adding a physician to your staff would, remember that you're adding the PA or NP at a fraction of the budget cost—e.g., \$250,000 for a physician in many hospitals and \$100,000–\$150,000 for most midlevel providers, according to Heroux.

"A PA/NP extends the clinical reach of the physician," says **Win Whitcomb, MD**, hospitalist and director of performance improvement at Mercy Medical Center in Springfield, MA, and author of the book *Hospitalists: A Guide to Building and Sustaining a Successful Program*. "The PA/NP can perform many of the same tasks as a physician, with the main difference being that the physician oversees the clinical activity of the PA/NP."

Creating a comfort zone

Prior to adding midlevel providers to your hospitalist staff and determining what their roles will be, it's important to make sure physicians and other hospital staff members will accept them, Heroux says.

"If you're the first department in the hospital to use midlevel [providers], expect some pushback," he says. "It's much easier to incorporate PAs/NPs into your staff if they are already being used in the ER or by private practice staff."

Note: If your program is the first one to use midlevel providers, be sure your hospital has a section in its by-laws that dictates how it will credential such individuals, says Heroux.

Regardless of whether other hospital departments are using midlevel providers, the most important step in determining whether it is appropriate to add PAs/NPs to your hospitalist staff is getting approval from your physicians, Whitcomb says. "Some physician hospitalists may be reluctant to work with them because of the complexity of hospitalized patient care."

By communicating to your physicians the benefits of midlevel providers, you can alleviate some of these fears, Heroux adds. "Create a transparent process with the medical staff, and make sure they understand how the process will work. You want your physicians to feel comfortable that it won't cause more work for them and that it will only increase their efficiency."

Midlevel capabilities

Because midlevel providers aren't full physicians, you must ensure you have a process in place that outlines what they can and can't do at your facility. As you set up the

"You don't want your midlevels to feel like all they do is charts and document—they should feel part of the caregiving environment."

—Roger Heroux, MHA, PhD, CHE

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Midlevel providers

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program, you'll probably discover that PAs and NPs can be helpful with just about every patient in some capacity, and their assets strongly outweigh any negatives, Heroux says.

PAs and NPs can perform all of the following tasks, according to Heroux:

- General admissions
- History and physicals
- Rounds
- Consults
- Educating and spending time with family and patients
- Discharge summaries
- Medical reconciliation
- Prescription writing
- Communicating with the patient's other physicians and case managers

In most cases, the PA/NP can perform these tasks without immediate supervision as long as the physician reviews the charts and documentation and then cosigns.

Heroux recommends assigning each PA/NP to one or two hospitalist physicians so they develop chemistry and work as a team.

Cautious reminders

Although the pros typically far outweigh the cons of adding midlevel providers to your hospitalist program, there are several items to keep in mind as you build the midlevel staff, according to Heroux and Whitcomb:

- **Do your work on the front end.** Before you start hiring PAs/NPs, make sure you have solid policies in place and put in the right effort into staff education, recruiting, and screening. Make sure you are familiar with all state laws governing PAs/NPs. Also, communicate your plans with your malpractice insurance carrier, because the physician has ultimate responsibility for each patient.
- **What are the billing rules?** Medicare covers the work PAs/NPs do, but Medicaid varies its rules by

state, and private insurers differ as to what they reimburse PAs and NPs for.

- **Beware of duplicating work.** The addition of midlevel providers to the staff can be negligible if there isn't proper communication with physicians.
- **Midlevel providers shouldn't be responsible for the most complex patients.** For patients with comorbidities or who are seeing many different subspecialists, it's best for physicians to take full responsibility for their care.
- **Many PAs/NPs don't have hospital experience.** You'll find that a lot of midlevel providers come directly out of school or from private practice, so educating them about the hospital environment will be crucial to their learning curve.

Making the system last

Once you've integrated midlevel providers into your hospitalist program, retention is just as important as it is with your physicians, Heroux says. Experienced PAs/NPs can make everything run more smoothly.

"This all starts with the physicians treating the midlevels with respect and wanting to educate them," Heroux says. "You don't want your midlevels to feel like all they do is charts and document—they should feel part of the caregiving environment."

A large part of building this relationship will be the day-to-day interaction the physicians have with the PAs/NPs. With each patient the PA/NP sees, there should be a conversation (think of a more detailed handoff) with the physician having ultimate responsibility, Heroux says.

For more detailed guidelines developed by Hospitalist Management Resources, LLC, turn to pp. 7–8. ■

Editor's note: To learn more about how hospitalists can successfully partner with midlevel providers, join the Society of Hospital Medicine and HCPro in March for an audioconference about the topic. Learn more by going to www.hcmarketplace.com and clicking on the Medical Staff tab.

Sample guidelines for utilization of midlevel practitioners

Editor's note: The following document is a guideline developed by Hospitalist Management Resources, LLC, and can serve as a guideline for organizations that currently use or are interested in using midlevel practitioners in their hospitalist program.

Although midlevel practitioner models may pose challenges, a growing number of hospitalist groups are incorporating them into their practices. This trend will continue to grow because many programs cannot successfully recruit board-certified, internal medicine physicians.

According to the most recent Society of Hospital Medicine (SHM) statistics, 16% of hospitalist groups now employ physician assistants (PA), whereas 20% have hired nurse practitioners (NP). The American Academy of Physician Assistants 2006 survey data indicates a rising number of PAs in hospital medicine. Approximately 7% of the more than 63,000 practicing PAs, about 37% of whom work in inpatient settings, reported functioning as "hospitalist PAs" in 2006, up from 6% two years earlier.

The following are examples of how hospitalist groups are using midlevels around the country:

- Midlevels, under the supervision of a rotating, lead hospitalist who serves as a triage officer, work in staggered 12-hour shifts to accommodate peak periods.
 - Handling admissions makes up approximately 60% of the midlevels' workload, whereas discharge preparation takes another 10% and the remainder is spent rounding with hospitalists.
 - Various studies show that midlevels significantly reduce hospitalists' legwork and paperwork.
 - Finding the right physician-to-midlevel mix has been a big challenge at many programs. Some programs have a 1:1 pairing, with one physician and one midlevel for each 10 patients.
 - In some programs, midlevels are assigned a smaller panel of less-acute patients for whom they are responsible, with hospitalists providing care oversight for all patients.
 - Midlevels can also take on much of the paperwork, including daily notes, discharge summary drafts, and coordination of studies and consultant evaluations.
- Because many hospitalists rotate off every week, midlevels bring continuity of care to patients with longer lengths of stay.
 - Some programs encourage midlevels to be active in developing the patient management plan. However, they still need MD input and supervision.
 - Most programs indicate that one of the biggest challenges is defining midlevels' scope of care, which can vary considerably. For example, many midlevels who learned specific skills and then functioned autonomously in ambulatory care have become primary providers in defined clinical situations, such as managing outpatient diabetes. A similar strategy needs to be developed for the very heterogeneous inpatient population.
 - Midlevels with acute care experience tend to concentrate on very specific and varied areas, such as handling admissions and/or discharges in one setting, caring for low acuity patients in another, and managing patients with defined clinical protocols.
 - Job descriptions should be designed to meet your local needs in order to develop specific roles for the midlevel scope, autonomy, and professional growth.
 - Most programs have established training programs for midlevels. New midlevels may need up to six months of training, whereas experienced midlevels might only require about eight weeks of training.
 - One successful hospitalist program in the Midwest reports that it has grown its program to include 25 PAs and 11 hospitalists who work in four discrete teams. There is a 2:1 ratio, with one PA rounding with a hospitalist during the day while another daytime PA handles admissions and consults. The midlevels handle most of the admission histories and physicals, collaborate on consults, and provide nighttime coverage for off-site physicians.
 - The majority of programs using midlevels strongly recommend not hiring PAs or NPs strictly to do paperwork and compile discharge summaries. This encourages dissatisfaction, which can contribute to a high turnover rate. Limiting the role of midlevels to administrative work only will limit their understanding of treatment plans and ultimately

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Sample guidelines for utilization of midlevel practitioners (cont.)

the quality of care. The key to expanding the role of mid-levels is the education the hospitalist group provides them.

- Most midlevels are trained to utilize protocols; therefore, one major barrier most groups report is getting midlevels to think in terms of systems or 'big picture' issues. A key strategy for success is to constantly reassess the midlevels' roles and workload. This will assure you are constantly refining their roles and responsibilities.
- Some groups have reported the successful utilization of midlevels in order to reduce the number of nighttime admissions by assuming responsibility for "hold-over" admissions.

Regulations and reimbursement considerations for midlevel practitioners

In order to appropriately maximize reimbursement and, at the same time, meet billing requirements, the following options should be considered:

- Per Medicare rules, NPs and PAs can bill out at only 85% of the physician rate if they bill under their own provider number.
- Another option is to bill under the Medicare Shared Visit Rule in which joint services are billed under the physician's billing number at 100% of the allowed rate. Under this option, the hospitalist must supervise the midlevel as patient face-to-face time. Procedures and consultations are currently excluded from Shared Visit billing.

- Some commercial payers have been slow to embrace NPs and PAs who bill on their own. Even in states where state and federal authorities allow midlevels to bill for services, many payers either don't recognize the CPT code modifiers that indicate midlevel services or don't include midlevels in their provider panels.
- In order to avoid billing issues, most groups to date don't allow midlevels to bill independently. Also, another reason to stay away from midlevel billing is that many referring physicians expect their patients to be seen by a physician.
- The attitudes of referring physicians can vary as much as those of commercial payers. There are markets in which midlevels are very well accepted; however, using an NP or PA in a market where the culture is aligned in different directions can create conflict, so be aware of the politics.

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Erin E. Callahan
Executive Editor

Be proactive to address hospitalist satisfaction

Considering the time, resources, and money necessary to recruit, hire, and retain qualified hospitalists, it's in your organization's best interest to ensure that these physicians are happy employees—not only today, but for years to come. An unhappy hospitalist can result in poor productivity, unhealthy relationships with coworkers, and in a worst case scenario, the physician leaving the organization. The hiring cycle then begins again, and the result is almost always a financial blow to the hospital.

There are many solutions to improve hospitalist satisfaction, ranging from immediate to short-term to long-term, and administrators committed to the growth of their hospitalist program should investigate each avenue to create a work environment that is satisfactory to their staff members.

The immediate

Before an organization hires a hospitalist, it should first create a hospitalist practice environment.

"This includes defining the practice mission, vision, and objectives, while creating practice policies, procedures, protocols, job descriptions, and practice scope of service," says **Kenneth G. Simone, DO**, founder and president of Hospitalist and Practice Solutions in Brewer, ME. "The hospitalist must be educated about this starting with the first contact during recruitment, through the hiring and orientation process."

Sylvia McKean, MD, FACP, medical director at Brigham and Women's Hospital/Faulkner Hospitalist Service in Boston, agrees that the best work environment is created in advance.

"Hospitalist satisfaction starts during the recruitment process," she says. "Although leaders are often eager to recruit talented people, it is critical not to set up false expectations about the job and instead emphasize the challenges or opportunities for improvement, as well as the benefits. What may be a problem for one applicant may be inconsequential to another. We try to encourage diversity and to be as honest as possible regarding challenges."

The organization should make an effort—if it hasn't already—to create a home within the hospital for hospitalists. Because hospitalists typically work throughout the hospital, finding a base for them can be problematic.

"Geographic localization fosters efficiency and teamwork, and may improve quality of care and patient and nursing satisfaction if the hospitalists are readily available to address urgent issues in one area," says McKean.

The short term

The hospital should also equip each hospitalist with his or her own desk and computer.

"Ideally, all hospitalists should have a desk and a computer even if they share an office with other hospitalists," says McKean. "Dedicated office space is essential for hospitalists who need a place to communicate to [primary care physicians], meet with students, check labs, and write notes."

At Brigham and Women's Hospital, some of the dedicated office space is referred to as the "group home," where hospitalists hold weekly and monthly meetings. "We also have a strategic executive council that addresses short- and long-term planning and keeps us on track regarding our mission," says McKean.

Additionally, hospitalists at Brigham and Women's have combined hospitalist rounds once per week for the residents and are actively engaged in teaching.

The hospitalist job isn't just patient care, and the different responsibilities can be sold to applicants as an opportunity to branch out. "They perform basic and clinical research; they are on hospital wards teaching residents and students, at hospital committee meetings, in the C-suite working with hospital administration, and in the library working on evidence-based clinical guidelines," says Simone. "The hospitalist's input and feedback must also be obtained along the way. A [hospitalist] typically develops ownership and loyalty when he or she feels [that his or her] opinion, work, and dedication are valued."

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Hospitalist satisfaction

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Simone suggests the following best practices for providers to achieve hospitalist satisfaction:

- Communicate
- Create a flexible provider schedule and practice model
- Clearly delineate job expectations and performance goals
- Provide practice support and tools that allow the hospitalists to effectively carry out their duties
- Allow provider input and feedback about the program
- Provide real-time feedback about job performance; this includes sharing clinical and financial data with the providers (e.g., make it transparent) and performing an annual evaluation for each
- Develop an integrated healthcare team and a culture throughout the hospital (starting with the hospital board and administrative team, to the hospital and medical staff)

The long term

Consider mapping out a career track for hospitalists who hope to spend some time growing with the program. According to Simone, some specifics of the program could include the following:

- Participation in a one-year hospitalist fellowship
- Future hospitalists taking the hospitalist residency training track
- A mentorship program
- Hospitalist practice management courses
- Society of Hospital Medicine leadership academy I and II

Otherwise, Simone says, providers should consider other long-term strategies to directly affect hospitalist satisfaction. Organizations may:

- Develop and implement an effective recruitment, retention, and orientation program
- Treat the program as a practice complete with office space, support staff, policies and procedures, job descriptions, etc.

- Provide administrative support for the program
- Provide systems that will track clinical and financial data (systems that ensure accurate, accessible, comprehensive, reproducible, and timely data)
- Implement effective and user-friendly electronic medical records
- Provide adequate specialty support and backup
- Provide modern technology (e.g., PET scan, 64- or 128-cut CT, cardiac CT, etc.)
- Offer competitive salary and fringe benefits
- Provide members of the medical and hospital staff support for the program (educational initiatives, putting hospitalists on the same footing as subspecialists, treating the hospitalists with respect, acknowledging the value hospitalists provide, etc.)
- Provide educational support for administrative duties such as coding and documentation, etc.

An incentive plan, awards, and leadership roles may also boost hospitalist satisfaction, says McKean.

Nevertheless, organizations should extend themselves to provide the best possible work environment. "Hospitalists want to feel valued for the work they do. They do not want to be viewed and treated as glorified house staff, residents, or officers," Simone says.

The hospitalist's biggest reason for discontent, says McKean, is "being a Band-Aid to fix the problems of others but not sitting at the table" to have a voice in how to help enact meaningful change. However, the responsibility for fostering a long and satisfying career in hospital medicine does not solely reside with the organization or the employer, she adds. Given the myriad practice opportunities currently available, hospitalists have a choice of where to work. Hospitalists need to reflect on their core values and ask key questions during the interview process to determine whether the "job-person fit" will actually work for them, she says. "Each hospitalist should strive to find a niche within the larger organization that allows for professional development." ■

Leadership positions offer tangible rewards

Satisfy personal goals and advocate for your program

The majority of people who enter the healthcare profession do so to make a difference in the lives of others. Most physicians feel the best way to make that difference is by treating patients.

But getting involved with leadership positions and becoming active in the hospital committee can often have a similar impact, says **Richard E. Rohr, MD, MMM, FACP**, vice president of medical affairs at Cortland (NY) Regional Medical Center.

“The best reason for wanting to become a hospital leader is to satisfy a passion for making healthcare work effectively,” Rohr says. “The worst reasons are to seek power, money, or an escape from patient care.”

That said, it’s vital to the success of a hospitalist program for some members of the department to seek out leadership positions and hold spots on decision-making hospital committees, says **Patrick J. Cawley, MD, MBA**, executive medical director at Medical University of South Carolina Medical Center in Charleston, SC.

“To maintain competitiveness in the hospital environment, the hospitalist department must have someone with significant leadership skills in a leadership position,” Cawley adds.

Leadership barriers

The obstacle many hospitalist programs face to obtaining these leadership positions is the relative youth of most staff members. Hospitalists tend to be younger than the average department physician, and as a result, they don’t feel ready for leadership positions or, even more commonly, don’t feel like it’s their place to aim for one, Cawley says.

“From what I’ve seen, the biggest reason there aren’t more hospitalist physicians on committees isn’t for lack of opportunity; it’s for lack of interest,” Cawley adds.

That’s why it’s essential for the hospitalist program manager to seek out leaders in the group and let them know these opportunities exist.

Without representation in the hospital leadership, hospitalist programs will have a difficult time increasing budgets and staff size, as well as stressing the positives of the department, according to Cawley. “The hospital might want to increase hospitalist admissions by 400 for the upcoming year, for example,” he says. “Without someone on the medical executive committee, that could become a mandate without anyone stating that it’s impossible without hiring more staff.”

Getting the edge

Putting hospitalists in the position to make a difference can be challenging for any program manager. You can’t just tell physicians you want them to be on a committee each year and then rotate them around, says Cawley.

“You need to find someone who wants to be a leader and wants to be in the position to make a difference,” he says. Otherwise, you’ll just end up with an individual who is waiting for his or her time on the committee to be over.

For staff members without much hospital leadership experience, committees really are what it’s all about, Rohr says. “Stature is gained by providing service to the medical staff and respecting its traditions,” he adds. “Fitting in with the staff and being willing to take committee assignments are what matters at the start.”

Once hospitalists establish credibility with other physicians, leadership opportunities and an audience for your programs needs will follow.

Hospitalists looking to move up should consider the following types of committees, according to Rohr and Cawley:

“From what I’ve seen, the biggest reason there aren’t more hospitalist physicians on committees isn’t for lack of opportunity; it’s for lack of interest.”

—Patrick J. Cawley, MD, MBA

> *continued on p. 12*

Leadership positions

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- Utilization review
- Pharmacy and therapeutics
- Infection control
- Quality improvement
- Case management
- Ethics

“Get on committees that are very clinically based and easy to serve on,” Cawley says. “Get a flavor for what happens there, and then you can consider moving into a position of leadership.”

To move on, however, Cawley says it’s necessary for the physician to have leadership skills—some of which can be learned, others that are more natural. “It’s worth spending some money each year to teach staff willing to become leaders how to become good leaders,” he says. “If you’re running a meeting with six agenda items, it takes some skill to stay on task and run the meeting so you get something out of it.”

As hospitalists gain experience on the clinically based committees, often the ultimate goal is to wind up as a member of the medical executive committee. This is where taking a class or two to understand the business of the hospital could be helpful, says Cawley. For example, to get into senior-level positions, a hospitalist should educate him- or herself about the financials of

the hospital, as well as coding issues and managing physician performance.

“Hospitalists must learn to manage people and administer a budget,” Rohr says. “Recruiting physicians and quality improvement is an important issue for smaller hospitals, but particular attention should be given to patient satisfaction and mandates from third-party payers.”

Keep on fighting

The process of moving up the ladder may be slow for young or inexperienced hospitalist leaders, but persistence often pays dividends, Cawley says. “If you find there isn’t room on a committee you think you should be on, don’t be afraid to speak to the hospital CEO. If you’re really interested, you’d be surprised how much a hospital respects physicians who want to be leaders.”

Rohr recommends making allies with other hospital departments such as nursing, pharmacy, and medical records. “It takes time to be accepted as a medical staff leader,” he says. “The nuances of medical staff politics require years to master.”

Staying with one organization also helps hospitalists get into leadership positions, and it’s crucial to get a master’s degree in business or administration if a vice president role is the goal, says Rohr. ■

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