

HOSPITALISTS IN COMMUNITY HOSPITALS

A *QHR* *White* *Paper*

Hospitalists, as more than one CEO has noted, are the future in acute-care hospitals. As health care has evolved – with family practice physicians mostly engaged in office-based practices, internal medicine specialists largely removed from caring for inpatients, and critical care and emergency medicine physicians taking specialized roles – hospitalists increasingly began to fill an important niche: the general care of hospitalized patients.

According to The Society of Hospital Medicine, there are 10,000 to 12,000 practicing hospitalists today. That number is expected to triple in the coming decade. By 2006, hospitalists are expected to admit more than 14 million patients nationwide.

The majority of hospitalists today work in urban or suburban facilities. However, some of the strongest drivers behind the hospitalist movement – such as physician satisfaction and the outmigration of patients to other, larger facilities – are major concerns of large and small hospitals in rural areas.

Though some analysts once theorized that community hospitals could not sustain hospitalist programs, experience has proven otherwise. To fill this information gap, QHR commissioned Cynthia Oster, PhD, to survey QHR hospital clients in two regions about their hospitalist programs, their future plans for such programs, or their reasons for not pursuing such programs. In addition, Dr. Oster's research illuminated the various models used by these community hospitals (which tend to differ significantly from hospitalist programs in urban or teaching hospitals); drivers; success factors; and challenges. She examined the programs at nine hospitals: LakeView Community Hospital in Paw Paw, MI; Allegan General Hospital in Allegan, MI; Three Rivers Area Hospital in Three Rivers, MI; Valley View Hospital in Glenwood Springs, CO; Park View Medical Center in Pueblo, CO; Arkansas Valley Regional Medical Center in La Junta, CO; Gritman Medical Center in Moscow, ID; Kadlec Medical Center in Richland, WA; and North Valley Hospital in Whitefish, MT.

DRIVERS

Behind the decisions of the surveyed QHR hospital clients to implement hospitalist programs were several common threads. Far and away the most frequently mentioned driver was physician retention and satisfaction, cited by all but one of the nine hospitals as a primary reason for implementing a hospitalist program. As primary care physicians became more and more overextended, working seven days a week as they attempted to balance their office practices with care for their hospitalized patients, hospitalist programs offered an opportunity, as one physician put it, to "get our life

back.” One hospital CEO recommended citing physician satisfaction and retention as the best strategy for obtaining medical staff support for a hospitalist program.

Concerns for the hospital's bottom line and quality of care, however, also were powerful drivers for roughly half of the hospitals that adopted hospitalist programs (as well as for others currently considering hospitalist programs). Several CEOs cited a need to halt erosion of patients to larger, more distant facilities. One envisioned the hospitalist program as part of a strategy to capture patients from other hospitals as it positioned itself as a regional medical center. Others adopted their programs in response to their competitors. Meanwhile, a number of hospitals also viewed hospitalists as a means to improve communication among the clinical staff and to establish or standardize clinical pathways, which in turn would lead to improved patient care and satisfaction.

In two communities, hospitalists helped remedy a shortage of primary care physicians or provide better coverage by internal medicine specialists. At Gritman Medical Center, the two hospitalists helped reduce costs by assuming several responsibilities – such as reading ECGs and cardiac echo-monitoring – that had been handled by four internists. In Pueblo, Colorado, the administration and medical staff found that hospitalists would help them provide better care for the community by spreading the risk of serving uninsured patients.

In most of the hospitals studied, the administration was the catalyst that drove the process of building board and physician support for a hospitalist program. In two communities, however, physicians themselves initiated the idea and persuaded the hospital board to support the initiative.

MODELS

In each of the nine hospitals that Dr. Oster examined, the hospitalist program followed a "voluntary" model. That is, primary care physicians

(PCPs) were not required to turn over their hospitalized patients to a hospitalist's care. None of these hospitals opted for a mandatory model, which runs the risk of alienating some PCPs. Instead, the hospitals contacted patients' PCPs to receive authorization for hospitalist services; unassigned patients were usually designated to the hospitalist service.

In other respects, however, the models adopted by the nine hospitals contained significant variation. For example, instead of providing round-the-clock hospitalist coverage, 365 days a year, two QHR client facilities offered hospitalist services only on weekends. At Gritman, hospitalists are in-house from 7-10:30 a.m. and 3:30-5 p.m. on weekdays. The rest of the time, a hospitalist is on call.

Other facilities have found their own balance between in-house and on-call coverage. Kadlec maintains four hospitalists in-house during the day, one on a swing shift and one on a night shift. North Valley provides in-house services 12 hours each day from Saturday to Monday morning, with on-call coverage (and a contractually stipulated, 10-minute response time) for the remainder of the weekend.

Staffing – Most of the studied hospitals rely on four or five physicians to provide hospitalist care, and most of the hospitalists (in line with national trends) are board-certified internal medicine specialists. However, one hospital in the study utilized five hospitalists in their model, a pulmonologist, two internal medicine specialists, two family practice specialists, plus a nurse practitioner who provides support.

At Kadlec, six hospitalists served inpatients, while three intensivists (each rotating between 24-hour shifts) cared exclusively for patients in the ICU. After the medical staff quality committee mandated that all ICU patients be "rounded on" by one of the intensivists, the hospital has adapted its otherwise voluntary model to become mandatory

for this particular unit. Recently, Kadlec also added three board-certified pediatricians to provide hospitalist care for younger patients.

All of the hospitals that provide 24/7/365 coverage engaged hospitalists on one-week rotations, creating more continuity between the physician and inpatients. One facility that began its hospitalist program with two-day rotations moved to the longer stints after discovering that the original model created too many patient "handoffs."

Contract Structure – In most of the QHR hospital clients that Dr. Oster studied, the hospitalists are drawn from local physician groups. In some cases, the hospital contracted with the group; other agreements were with individual physicians (one hospital contracted with individual physicians from two different physician groups). In these cases, the physicians maintained their office practices when not on hospitalist duty. At two facilities, the hospitalists were employees of the hospital. Kadlec, following a hybrid of this model, created a LLC that employed its hospitalists, to eliminate the referring physicians' risk of permanently losing their patients to hospitalists with a private practice.

The majority of contracts involved a stipend to the physician group annually (ranging from \$180,000 to \$350,000); monthly (\$10,000); weekly (\$3,500); daily (\$300 per physician); or for a weekend (ranging from \$2,500 to \$3,000). When the hospital contracted with a group, the physicians billed for their services. Where hospitalists were hospital employees, the hospital was responsible for billing and collection. At Gritman, the hospital billed only for services provided between 7 a.m. and 5 p.m. on weekdays, when hospitalists were in-house; the physicians billed for their own services when they responded to calls after hours or on weekends.

OUTCOMES

At nearly all of the nine hospitals, primary care physicians responded well to the voluntary model.

Six reported that more than 95% of the PCPs in their service area relied on the hospitalists for inpatient care. Only two reported usage below 75%, and none were below 50%. The two facilities with the lowest PCP usage rates also were the two whose programs were less than three months old at the time of the survey.

Because only three of the hospitalist programs studied have operated for more than one year, there was insufficient data to quantify the financial impact of the hospitalist programs. Dr. Oster found that most of the nine hospitals believed that, thus far, their programs operated at a net loss. However, at least one CEO suggested that, while admissions had not risen, the hospital would have experienced a decrease in admissions without the hospitalists.

Notably, the hospital with the most established program – LakeView, which began offering hospitalists in 1993 – enjoyed the biggest financial benefit. In fact, says the CEO, the program helped LakeView achieve a major financial turnaround. Admissions rose 10–15 per month, to 75–80 patients per month. That increase, combined with more efficient resource utilization, has led to stronger revenues and profits. Meanwhile, physician satisfaction also increased, leading to less burnout and turnover. Quality of care improved, as measured by a lower infection rate, and average length of stay has decreased from six days to three.

If quantitative indicators are not yet clear for most of the QHR hospital clients, almost all concur that hospitalists have made important qualitative improvements. Virtually across the board, CEOs noted that physician satisfaction – the number one driver behind most programs – had notably improved, while the feeling of being overtaxed had diminished. Almost all of the hospitals also reported improved relationships between physicians and RNs, owing largely to better and more consistent communication. Several also pointed to improvements in patient care, ranging from improved discharge planning to the development and consistent application of clinical pathways. All

of these factors, in turn, have contributed to improved patient satisfaction in all of the programs that had been operational for more than two months. None of the nine hospitals reported any significant complaints after their programs were in place.

SUCCESS STRATEGIES

By and large, the surveyed hospitals encountered few obstacles to developing and implementing their hospitalist programs. When challenges arose, however, they could be formidable. Most often, physicians were the impediment. In some communities, primary care physicians feared loss of control or income. Others had to deal with politics among the hospital's medical staff or with economic tensions between the hospitalist and non-hospitalist physician groups.

In all of these cases, CEOs reported that transparency and clear, consistent, two-way communication were essential for creating a successful program. Administrators must always be ready to listen to – and address – the concerns of all stakeholders. All but one of the nine hospitals (which engaged an outside consulting firm) partnered with physicians through every step of developing the model for its hospitalist program. That level of involvement, CEOs said, helped reduce resistance and increased buy-in among local physicians, as well as their utilization of the hospitalists' services.

Don't just involve the medical staff, advised one administrator; include the nursing staff and anyone else involved in patient care. And identify a champion among the medical staff who can help build support for the program among fellow physicians. Likewise, the CEOs concurred that transparency – sharing with physicians and other stakeholders information about model development, implementation and, particularly, financial structures – was of critical importance.

Staffing the hospitalist program from local physicians was another widely used success strategy. Only two of the nine hospitals in the study relied on recruiters to bring new physicians to the hospital – and then only because there were not enough physicians in the community who were willing or qualified to serve as hospitalists. Local staffing not only facilitated acceptance of the program among the medical community but also contributed to higher patient satisfaction.

Third, many of the CEOs offered a common-sense recommendation to other hospitals considering the addition of hospitalist services: Talk to others. The administration of Three Rivers traveled to Vermont and Connecticut to study hospitalist programs at other facilities. The management team at Allegan General Hospital modeled its program on the successful, well established program at LakeView. Before beginning your own program, advised the CEO at Kadlec, consult with a minimum of three or four other programs to draw on their experience and learn the do's and don'ts of establishing a hospitalist program.

Of the 10 hospitals in the study that did not yet provide hospitalist services, Dr. Oster found that all but two had either discussed or made active plans for developing a program. That reality points to another success strategy expressed by one CEO: "Find a way to do it. There will always be resistance, but do it anyway." Hospitalist services, in other words, are becoming an inevitability for all hospitals, including (or, perhaps, especially) rural, community hospitals. Those that embrace the future sooner will reap greater benefits later. "In the end," said the "just-do-it" CEO, this was a win-win for all stakeholders."

For more information about how QHR can help you resolve your hospital challenges please call Susan Hassell, Vice President, at 866-371-4669.

Table 1: Region Three Hospitalist Model Description

Descriptor	Model 1	Model 2	Model 3
Model Type	Voluntary	Voluntary	Voluntary
Duration of Operation	13 years	9 months June 3, 2005	Expected June 2006
Staffing	4 physicians 1 week rotation	4 physicians (3 in place) 1 week rotation	2 physicians (1 in place) 1 week rotation
Medical Specialty	Internal Medicine Board Certified	Internal Medicine Board Certified	Internal Medicine Board Certified
Number of Patients	9 or 10 per day	10 per day	24 per day
Coverage Schedule	24/7/365 30 minute response time	24/7/365 In house until 1200 Rapid response after 1200	24/7/365 In house 10 hrs/day M - F
Hospitalist Clinical Responsibilities	Assigned PCP patents Unassigned ED patients	Assigned PCP patients Unassigned ED patients	Assigned PCP patients Unassigned ED patients ICU, acute floor, rehab unit, medicine service, all in house procedures
Office Practice	Yes - 3 weeks per month None while on hospitalist duty	Yes - 3 weeks per month None while on hospitalist duty	No Hospitalists are employees of the hospital
PCP Usage	95%	80%	70%
Structure	Contract with groupContract with the individual physician	Contract with the individual physician	Employment contract with the individual physician
Financial Arrangement	Annual stipend Hospitalists bill directly for services	Annual stipend Hospitalists bill directly for services	Annual stipend Hospital bills and collects
Decision to Operational	2 to 3 months	6 months	18 months

Table 2: Region Three Hospitalist Model Development/Implementation and Outcomes

Descriptor	Model 1	Model 2	Model 3
Development/Implementation			
Drivers	Retain hospital admissions Competitor had a program in place Workflow issues for patients and physicians PCPs over extended	Difficulty securing IM call coverage Recruitment and retention of IM doctors Poor lifestyle of the IM physicians IM physicians over extended	Retain hospital admissions Improve quality of care
Obstacle	Keeping the physician out of their office while on hospitalist duty	Politics among the local physicians	PCPs in the community
Outcomes			
Positive	↑ number of admissions ↑ revenues/profits ↑ efficiency ↑ patient satisfaction ↑ physician satisfaction + PCP lifestyle + RN/MD relationship ↓ physician burnout ↓ infection rate ↓ LOS	↑ PCP productivity ↑ PCP office efficiency ↑ patient satisfaction ↑ physician satisfaction ↑ UR efficiency + IM lifestyle + RN/MD relationship	Unknown Implementation date June 2006
Negative	Administration beholden to one group physicians Medical staff beholden to the same one group of physicians	None	Unknown Implementation date June 2006

Table 3: Region Five Hospitalist Models 1, 2 and 3 Descriptions

Descriptor	Model 1	Model 2	Model 3
Model Type	Voluntary	Voluntary	Voluntary
Duration of Operation	4 to 5 years	18 months	6 months October 2005
Staffing	5 physicians 1 week rotation	5 physicians 1 NP 1 week rotation	4 physicians Weekends only
Medical Specialty	Internal Medicine Board Certified	Pulmonology (1) Internal Medicine (2) Family Practice (2) Board Certified	Family Practice (1) Internal Medicine (3) Board Certified
Number of Patients	10 - 30 per day	30 - 50 per day	20 - 25 per day
Coverage Schedule	24/7/365 In house 9 hrs/day M - F Rapid response after 1700	24/7/365 In house 8hrs/day M - F On call after hours	5 PM Friday -7 AM Monday In house most of weekend
Hospitalist Clinical Responsibilities	Assigned PCP patients Unassigned ED patients Rounds, in house procedures, admissions	Assigned PCP patients Unassigned ED patients Rounds, in house procedures, admissions	Assigned PCP patients Unassigned ED patients Rounds, admissions, procedures No mechanical ventilation patients
Office Practice	Sometimes Only see patients in their office if hospital is slow	Yes - Pulmonologist No - Other 4 physicians	No - 3 locum tenens physicians Yes - 1 local IM physician

Table 3: Region Five Hospitalist Models 1, 2 and 3 Descriptions (Continued)

Descriptor	Model 1	Model 2	Model 3
PCP Usage	100%	70% PCPs contract with the hospitalists	100%
Structure	Contract with group corporate entity	Contract with the group corporate entity Pulmonologist employer of hospitalists	Employment contract with the individual physician 34 weekends - locum tenens FP from Utah 18 weekends - 2 locum tenens IM and 1 local IM
Financial Arrangement	Annual stipend Hospitalists bill directly for services	Daily stipend Hospitalists bill directly for services	Weekend stipend Hospital bills and collects
Decision to Operational	3 to 6 months	6 months	2 months

**Table 4: Region Five Hospitalist Models 1, 2 and 3
Development/Implementation and Outcomes**

Descriptor	Model 1	Model 2	Model 3
Development/Implementation			
Drivers	<p>Improve quality of care</p> <p>Improve patient satisfaction</p> <p>Retention of IM doctors</p>	<p>↓ availability of PCPs</p> <p>IM doctors leaving community</p> <p>Provide care to uninsured</p> <p>Community physicians over extended</p> <p>Improve quality of care</p>	<p>Increase hospital admissions</p> <p>Improve resource utilization</p> <p>Community physicians over extended</p>
Obstacle	<p>No notable obstacles</p> <p>No resistance from community physicians</p>	<p>Economic tension among the hospitalists and sub-specialists</p> <p>Politics among the physicians</p>	<p>Defining exactly what the hospitalist does</p> <p>Hospital culture</p>
Outcomes			
Positive	<p>↑ quality of care</p> <p>↑ patient satisfaction</p> <p>↑ physician satisfaction</p> <p>+ IM lifestyle</p> <p>+ RN/MD relationship</p>	<p>Stable patient volumes</p> <p>↑ patient satisfaction</p> <p>↑ physician satisfaction</p> <p>↓ Length of Stay</p> <p>Improved discharge planning</p> <p>+ physician lifestyle</p> <p>+ RN/MD relationship</p>	<p>Access to better care</p> <p>↑ patient satisfaction</p> <p>↑ physician satisfaction</p> <p>Breakeven point</p> <p>+ RN/MD relationship</p>
Negative	None	None	None

Table 5: Region Five Hospitalist Models 4, 5 and 6 Descriptions

Descriptor	Model 4	Model 5	Model 6
Model Type	Voluntary "Quasi" Hospitalist Model	Voluntary Evolving beyond	Voluntary
Duration of Operation	2 months March 1, 2006	Hospitalist - < 1 year Intensivist - < 1 year Pediatric - < 1 month	4 months
Staffing	2 physicians 1 week rotation	Hospitalists - 5 physicians Intensivists - 3 physicians Pediatrics - 3 physicians	4 physicians Weekend only
Medical Specialty	Internal Medicine Board Certified	Internal Medicine (5) Critical Care Medicine (3) Pediatrics (3) Board Certified	Internal Medicine Board Certified
Number of Patients	6 per day	Hospitalists 35 to 45 per day Intensivists 3 to 9 per day Pediatrics not sure as new program	15 per day
Coverage Schedule	In house 5 hrs/day 7 AM - 10:30 AM and 3:30 PM - 5 PM M - F Weekends and after hours covered by on call physician	Hospitalists 24/7/365 3 in house during the day 2 on call Intensivists 24/7/365 24 hour shifts Pediatrics 24/7/365 Rotation not stabilized	7 AM Saturday to 7 AM Monday In house 12 hrs/day 10 minute response time when out of house

Table 5: Region Five Hospitalist Models 4, 5 and 6 Descriptions (Continued)

Descriptor	Model 4	Model 5	Model 6
Hospitalist Clinical Responsibilities	Assigned PCP patients per request of the on call physician Unassigned ED patients per request of the on call physician Other duties: read ECGs, cardiac echo monitoring, holter monitoring/reading	Assigned PCP patients Unassigned ED patients Medical staff quality committee mandated that all ICU patients be rounded on by an intensivist	Assigned PCP patients Unassigned ED patients Other duties: ICU, in house procedures, admissions
Office Practice	Yes Between 10:30 AM and 3:30 PM	No	Yes Reduced hours the week on hospitalists duty
PCP Usage	More than 50%	100%	100%
Structure	Each hospitalist is a member of a different group Contract with the group the hospitalist is a member of	Hospitalists/Intensivists are employed by an LLC owned by the hospital Hospital contracts with the LLC for services Hospital contracting with the Children's Hospital in Seattle to staff the model	Employment contract with the individual physician
Financial Arrangement	Monthly stipend Hospital bill directly for all services between 7 AM and 5 PM and retains fees collected Physicians bill for services after hours or on weekends	Reimbursement for expenses LLC has an outside billing service for hospitalist billing	Weekend stipend Hospitalist bill directly for services
Decision to Operational	3 months	8 months	6 months

**Table 6: Region Five Hospitalist Models 4, 5 and 6
Development/Implementation and Outcomes**

Descriptor	Model 1	Model 2	Model 3
Development/Implementation			
Drivers	Surgeons needed medical management of their patients Cost avoiding strategy	Want to become a regional medical center Easier to get and receive transfers Quality of care	Poor lifestyle of the IM physicians IM physicians over extended
Obstacle	PCPs in the community Hospital BOD about the funds needed to subsidize program Two competitive IM physicians who are the hospitalists had to work together	Recruiting physicians that are board certified	PCPs in the community
Outcomes			
Positive	Development of ventilator management protocols No patient or physician complaints so far Not enough data available	↑ PCP productivity ↑ PCP office efficiency ↑ patient satisfaction ↑ physician satisfaction ↑ UR efficiency + IM lifestyle + RN/MD relationship	Not enough data available ↑ PCP productivity ↑ PCP office efficiency ↑ patient satisfaction ↑ physician satisfaction + IM lifestyle ↓ IM burnout + RN/MD relations
Negative	Communication between specialists and PCPs not real fluid	None	Money loser currently