Goals for this session:

- Review topics I’m asked about regularly, and that may be part of a “level 2” SHM practice management course
  - Distributing referrals among hospitalists in the group
  - Surge capacity
  - Evolving scope of hospitalists’ clinical practice
  - The “right” patient volume (workload)
  - Surgical hospitalists
- Provide ample time for discussion
DISTRIBUTING NEW REFERRALS AMONG HOSPITALISTS IN THE GROUP

Patient distribution among daytime doctors

Common methods

- **Sequentially**: each doc gets one new patient in sequence (like dealing a deck of cards)
- **By patient location**: e.g., Dr. Simon gets all new patients going to floor 2 & 3, Dr. Garfunkel gets patients going to floors 4 & 5
- **Load leveling**: patients assigned to keep everyone’s AM census even
Patient distribution among daytime doctors

Uncommon methods:

- Uneven assignment – e.g., a doc may be responsible for many (all?) admits today; none tomorrow
- By PCP- I get all patients from PCPs Harrison & Lennon, you get all from PCPs McCartney and Starr
- Hospitalist and patient stay connected over time – a patient is always admitted by same hospitalist

Patient assignment: special cases

- “Bounce backs”
- One hospitalist is at the cap, others aren’t
- Consult requested of a specific hospitalist
- Hospitalists with unique skills, e.g., ICU expertise
- A patient “fires” the hospitalist
Patient assignment: related issues

- Separating daytime admitter and rounder duties
- Triage pager (aka “hot pager”)
- Time spent load leveling
- Do nurses and other doctors know who is attending?
  - e.g., does radiologist know who to call w/ corrected CT report morning after admit?
- Patient satisfaction
  - ?Damaged when admitter can’t let patient know name of next hospitalist

Method of assignment affects continuity

Calculate % patients who see same hospitalist throughout

Assumptions:
- Avg. LOS = 4 days
- Hospitalist works 7 consecutive days

No patients assigned to doc the day before rotating off: 71%

Doc assigned equal share of patients daily, including day before going off: 57%
Doc gets no new patients day before rotating off:

**Benefits:**
- Better continuity (fewer handoffs)
- Next doc picks up smaller list
- Time to better “tee up” patients for next doc

**Costs:**
- Other docs busier if one exempted from new patients
- Only one doc can rotate on/off daily

Patient assignment: Measuring success

- Feels fair to hospitalists
  - Doesn’t have to mean patient loads leveled daily
- Supports good hospitalist-patient continuity
- Attending assigned at time admit orders written
  - Others in hospital always know which hospitalist caring for patient
  - Patients not left wondering name of doctor who will see them next
Surge Capacity

Common methods:
- Docs just work harder/faster when needed
- Overstaff for average volume
- Director gives up admin time to see patients
Surge Capacity

Uncommon methods

- Cap for whole hospitalist practice
- Jeopardy system
- Extend scheduled shift

Surge Capacity: Some inconvenient truths

The following inhibit the regularly scheduled docs’ ability to manage above average volumes:

- Maximizing each doc’s average daily workload (often done to maximize days off)
- Scheduling in fixed shifts (i.e., same shift duration daily)
- Fixed compensation (i.e., absence of significant production-based component)
The biggest challenge our facing our field?

THE EVOLVING SCOPE OF HOSPITALISTS’ CLINICAL PRACTICE

Part 1 of 4: A few facts

THE EVOLVING SCOPE OF HOSPITALISTS’ CLINICAL PRACTICE
### SHM 2008 survey data

**Mean Percent of Encounters by Category:**

- Admissions, Follow-ups, Discharges: 73.6%
- Consultations: 8.2%
- Observation Days: 8.0%
- Critical Care: 4.0%
- Procedures: 2.0%
- Office Encounters/Consultations: 1.1%
- SNF/Rest Home Visits: 1.0%
- ED Encounters: 0.9%
- Other Encounters: 1.1%

No surprise, but which patients do hospitalists admit? Others admit?

### SHM 2006 survey data

% hospitalist groups offering each service:

<table>
<thead>
<tr>
<th>Service</th>
<th>% Offering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations</td>
<td>99%</td>
</tr>
<tr>
<td>Care of unassigned patients</td>
<td>96%</td>
</tr>
<tr>
<td>Accept referrals from PCPs</td>
<td>95%</td>
</tr>
<tr>
<td>Surgical co-management</td>
<td>85%</td>
</tr>
<tr>
<td>Care for patients in critical care units</td>
<td>75%</td>
</tr>
<tr>
<td>Procedures</td>
<td>69%</td>
</tr>
<tr>
<td>“code” coverage</td>
<td>43%</td>
</tr>
<tr>
<td>Rapid response team coverage</td>
<td>35%</td>
</tr>
<tr>
<td>Patients in SNFs</td>
<td>20%</td>
</tr>
<tr>
<td>Long term acute care (LTAC)</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>19%</td>
</tr>
<tr>
<td>Patients in newborn nurseries (Peds only)</td>
<td>59%</td>
</tr>
</tbody>
</table>
SHM 2006 survey data

% hospitalist groups that perform the following non-clinical activities:

- Committee participation: 92%
- Quality improvement: 86%
- Practice guidelines: 72%
- Pharm/Therapeutics committee: 64%
- Utilization review: 59%
- CPOE/Information systems: 54%
- Teaching: House Staff: 51%
- Teaching: Non MDs: 36%
- Recruit/Retain MDs: 31%
- Community service: 25%
- Disaster Response Planning: 25%
- Research: 23%

Summary of available facts regarding hospitalist scope of practice

SHM doesn’t have an official position on most scope issues, and facts about hospitalist scope of practice are very limited

and

The facts that are available don’t provide conclusions about what should and should not be in hospitalists scope of practice

therefore...

There is a lot of room for various opinions and debate
Part 2 of 4: A lot of opinions

THE EVOLVING SCOPE OF HOSPITALISTS' CLINICAL PRACTICE

Wide range of opinions

"Hospitalists are just internists without an office practice. Their scope should be identical to their training!"

Hip fracture is a surgical admission and hospitalists should only consult!

"All referrals are good referrals and good for business ($$). Hospitalists should eagerly say yes to anything another doctor asks of them! They should be universal admitters!"
**What is a dump an inappropriate referral?**

Marginal admit on Fri evening from PCP who refers regularly

Hypertensive intracranial hemorrhage neurosurgeon refused to admit.

Elective total knee replacement w/o significant medical issues; orthopedist wants you to be attending

18 weeks pregnant w/ asthma

Pt. discharged Fri afternoon after 3 wk stay. Returns to ED 1 hr. later b/o low BP on arrival at SNF. Discharging doc says “admit to hospitalists.”

**What about surgical co-management?**

“Good for patient care.”

“I can get the hospitalist to do all the paperwork and take the calls at night!”

“You’re kidding. These guys want me to do what?!”

“Good for patient care”

“Good for patient care”

Co-management. Isn’t that just a euphemism for hospitalists keeping the money making specialists happy?
Surgical Co-management: the good...

- May reduce confusion regarding which doctor addresses a particular issue, e.g., post op pain, fever, SOB, etc.
- One study: Improved minor patient outcomes (e.g., fewer UTIs), no change in major outcomes
- More efficient surgical service?
- More cost effective use of hospital resources?

Surgical Co-management: the bad...

- Other docs will gradually become less responsive and available
  - Medical staff culture could tilt toward: hospitalist needs to serve the other doc and not the other way around
  - Increased wait times to surgery, etc.
- Medicare and other payers don’t recognize co-management
  - Hospitalist unable to bill for some co-management services
What is best for your practice?

- Hospitalists should position themselves to decide scope issues for themselves as much as possible
  - Hospitalists must remember that the healthcare system will insist they adjust their scope of practice as time goes by
    - A dump today might be core business tomorrow
    - Digging in your heels and trying to maintain status quo isn’t a viable option

Part 2 of 4: Some historical context

THE EVOLVING SCOPE OF HOSPITALISTS’ CLINICAL PRACTICE
History of Emergency Medicine

Future of Hospital Medicine?
How will hospitalists expand the breadth of their expertise? The same way other specialties have.

Open cholecystectomy

Self-study
“Live” courses
Proctoring
Etc...

Laparoscopic cholecystectomy

Part 3 of 4: Who decides a hospitalist group’s scope of practice?

THE EVOLVING SCOPE OF HOSPITALISTS’ CLINICAL PRACTICE
Determinants of hospitalist scope of practice

- High functioning groups will manage and control this themselves by thoughtfully responding to the needs of stakeholders.
- Groups that continually resist all change will have it thrust on them and will lose the chance to influence it.
  - Decide where to stand firm and where to give in.

Plan your future

one possible approach...

- Write down the following annually:
  - all things hospitalists have been asked to do by others (including the unreasonable requests)
  - all the things the hospitalists think might provide value to stakeholders even if they haven't been asked to do them
- As a group, the hospitalists rate the importance and appropriateness of each idea
- Plan to implement 1 – 3 new services annually
- When stakeholders complain the hospitalists haven’t yet started providing a desired service, point out the new services.

Don’t try to swim against the riptide to shore, but it is OK to swim across it or ride it out.
Who says 15 patients a day is the right number?

THE "RIGHT" PATIENT VOLUME

Which doctor works too hard?

Rounded on 12 yesterday

Avg. 9 patients/day

8 admits per night shift + ton of crossover

15 – 22 encounters/day

25-32 patients/day

ADC 22-15

May have seen a patient last year, can’t really remember
Vocabulary

- Number of patients a day ≠ census
- Visits, billable visits, encounters – often used interchangeably, but may mean different things to different people

Daily workload: only part of the story

- Annual workload (or other long period) is more informative
- Average workload per FTE in the whole practice is important
- Frequency that encounter volume exceeds “safe” limit may be more important than whether average encounter volume is OK
Who should get to decide how many patients you see in a day... in a year...

Data from surveys done by SHM or MGMA, etc?
Your group leader, VPMA, hospital CEO?
Knowledgeable consultants in Hospital Medicine?
Bob Wachter?

You should decide for yourself!

General surgeons adopting the hospitalist model of practice

SURGICAL HOSPITALISTS
Some definitions...

**Surgical Hospitalist:**
A general surgeon with a practice focused on hospitalized patients, usually including trauma care.

**Acute Care Surgery:**
An emerging discipline of general surgeons focused on emergency care, sometimes including a broader scope of practice such as cranial burr holes, etc. Lots of overlap between this and the discipline of surgical hospitalist practice.

**Traumatologist:**
A general surgeon or orthopedist with a practice focused on trauma care.

These terms don’t have unambiguous universally accepted definitions and connotations. There is room for other points of view.

---

**Surgical vs. “Medical” Hospitalists**

<table>
<thead>
<tr>
<th>Medical Hospitalists</th>
<th>Surgical Hospitalists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger practitioners</td>
<td>Older practitioners</td>
</tr>
<tr>
<td>Proactive strategy: hospitals supported growth initially as a method to reduce costs, improve quality</td>
<td>Reactive strategy: hospitals pursue SH to avoid paying all surgeons for call and to get better service in return for payment</td>
</tr>
<tr>
<td>Higher patient volumes</td>
<td>Lower patient volumes</td>
</tr>
<tr>
<td>Rarely have outpatient work</td>
<td>Nearly always have some outpatient work (hospital f/u visits)</td>
</tr>
<tr>
<td>Likely to have in-house night shift</td>
<td>Rarely have in-house night shift</td>
</tr>
<tr>
<td>Often earn more than PCPs in traditional (office) practice</td>
<td>Often earn less than general surgeons in traditional practice</td>
</tr>
</tbody>
</table>
Drivers of surgical hospitalist growth

- The impending disappearance of the general surgeon*
  - more surgeons retiring than entering practice
  - Shortage of 1,300 general surgeons by 2010?**
- Hospitals face increased pressure to pay general surgeons to cover ED call
- The hope that quality and efficiency can improve

General surgeons as percent of total physician workforce**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>~8%</td>
</tr>
<tr>
<td>2005</td>
<td>~5%</td>
</tr>
</tbody>
</table>

Source: Physician Characteristics and Distribution in the US, 2007. Published by the AMA.


Assessing the hospital’s ROI

- Happiness of other med staff members, especially general surgeons relieved of ED call
  - Many institutions report increases in overall volume of elective surgical cases by non-hospitalist surgeons
- Potential reductions in LOS and time spent waiting for surgeon
- Decreased variation in practice patterns and surgical supplies
- Increased attentiveness to hospital protocols, quality measures, etc
- Surgical hospitalist program may be a critical element in hospital raising their trauma level designation (e.g., to from level 3 to level 2)
Lessons learned from medical hospitalist programs

- Even with generous financial support from hospital, groups can manage themselves poorly and fail. Hospital may want to employ surgical hospitalists and provide professional administration/management.
- Pay close attention to the SHs’ work schedule. It can have dramatic influence on program productivity and costs.
- Avoid hourly or fixed annual salaries. Instead, ensure a significant component based on productivity (e.g., 50% or more) and a meaningful quality incentive (e.g., 15 – 20%).

Lessons learned from medical hospitalist programs (cont.)

- Presence of SH leads to shift in what others expect of surgeon
- Acknowledge you may tend to attract doctors who have washed out in other careers and won’t succeed as SH.
- Non-compete clause much less important for hospitalists since they don’t “own” any patients or referral streams. Non-compete may simply interfere with recruiting.
- Documentation/billing/coding is often managed very poorly.
The future...

- Doctors in nearly every specialty are seeking to leave the hospital behind if possible.
- Hospitals increasingly provide financial support and/or employment for physicians, often via the hospitalist model of practice.
- An increasing segregation between inpatient and outpatient doctors? (similar to other countries).
- Payers, led by Medicare, increasingly likely to pay a “universal DRG” to hospital for all components of care. Hospital and physicians negotiate how to divide it up.