

# WHY DO HOSPITALIST PROGRAMS **Risk Failure?**

The purported benefits of hospital medicine, including reduced lengths of stay, cost savings and quality improvement for the hospital, and higher satisfaction for primary care physicians and patients, have been widely discussed. But are these positive outcomes always ensured when a hospital or a medical group decides to start a hospitalist program?

If the program is launched without adequate planning, a viable business plan, sufficient staffing, or other basic components of any successful business enterprise, the results may disappoint. The program may not deliver desired outcomes in terms of quality or cost savings. Hospitalist staff may become disillusioned, overworked, or burned out and then leave. The program might even fail, which is doubly problematic once physicians and hospital administrators have gotten used to the advantages of having hospitalist coverage in their facility.

## **WHAT NOT TO DO ... AND HOW TO FIX IT**

A hospitalist service started by Lewis-Gale Clinic, a multi-specialty medical group in Salem, Va., and practicing at 521-bed Lewis-Gale Medical Center, experienced serious problems after its launch in 1997.

"Our program initially wasn't a true hospitalist program per se, but more like a service provided to internists in the medical group," says Harsukh Patolia, MD, the hospitalist program's medical director. "I was the first person hired. I made it clear that I wanted to be a hospitalist. But there were not many models available for us to base our program on."

Demand was great from clinic physicians, who no longer had time to see their patients at the hospital, says Dr. Patolia. Three additional hospitalists were hired, but by 1999, one had left and the others were stressed out and overworked. "We were working very hard," he says. But the program was dependent on *locum tenens* physicians to fill shifts, and quality was starting to suffer. "I'm not sure we were on the brink of failure, but there was a lot of dissatisfaction."

Jon Ness, then the medical group's administrator, identified a problem with the hospitalist service soon after he started work in Salem in 1999. "My sense was that both the hospital and medical staff really wanted the program and didn't want to see it fail. But they didn't understand why we were having so many challenges with it," he says. "The first thing we did was a thorough clinical and admin-

## Strategic planning remains essential during startups

■ **By Larry Beresford**

istrative review of the program. The more information I collected, the more concerned I got."

Recognizing that there wasn't enough expertise within the organization to sort out the problems, Ness contacted Colorado Springs, Colo., consultant [Roger Heroux of Hospitalist Management Resources, LLC](#). Additionally, he approached Lewis-Gale Medical Center's new

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CEO, James Thweatt, who also realized that there was a problem with the program.

“If they hadn’t come to me, I would have gone to them with my recommendation for a consultant,” adds Thweatt. Basically, there were serious lacks in terms of logistical support for the service, of clarity in its strategic goals, and of authority for the practice’s leadership, while its relationship with the rest of the clinic was also deteriorating.

“With the changing face of healthcare, a viable hospitalist program was a necessity,” Thweatt says. He also had to satisfy the demands of physicians—not only those belonging to the group practice but also independent primary care practitioners in the community—or else they might take their patients to a competing hospital.

Ness and Heroux surveyed physicians about their needs and desires for the program, visiting a number of key physicians in their offices. Another challenge they handled was to negotiate a contract with the hospital for the hospitalists’ services, including a subsidy to reflect their 24/7 coverage in the hospital. Then they needed to agree on appropriate quality and financial performance measures by which to gauge the program’s success.

“With Roger’s help, we all got smarter about what a true hospitalist program was,” says Ness. “What I discovered was that a hospitalist program is no different than any other significant business venture. It needs its own goals, leadership, and overarching business plan. You can’t just put it in place and assume that you’ll be successful. It requires just as much discipline, rigor, and hard work as other businesses.”

### PRACTICE MANAGEMENT TASKS

A comprehensive list of why some hospitalist programs risk failure, including problems with recruitment, retention, scheduling, compensation, communication with primary physicians, buy-in, marketing, data analysis, financial performance, and return on investment for the hospital, would closely track with the content of any hospitalist practice management course. One such course, “Best Practices in Managing a Hospital Medicine Program,” sponsored by SHM and presented at UCSF’s Management of the Hospitalized Patient meeting in San Francisco on October 11 by some of the field’s top consultants and practice leaders, covered these topics.

Heroux was on the UCSF faculty, and he presented his model of the Fourth Generation hospitalist practice that has evolved from a simple rounding model with daily assignments of outpatient physicians, a rotational model with one-week assignments of outpatient physicians, and a group of dedicated hospitalists who lack administrative support. The

Fourth Generation hospitalist program is a sustainable, dedicated program that enjoys full clinical and administrative support, including a practice manager and a case manager.

Such a practice provides dedicated 24-hour coverage with realistic staffing ratios, employs effective practice leadership, is strategically aligned with the hospital and medical community, and utilizes a financial management system and data sets for benchmarking of key performance measures demonstrating its value. Without these components in place, Heroux says, the hospitalist program risks serious dysfunction and eventual failure.

Reflecting on his work with Lewis-Gale and other clients, Heroux believes it is important to be disciplined and deliberate about evaluating the real need for a hospitalist service in the community. “Talk to your medical staff. Find out what they want and need from the service. Then prioritize those needs because you can’t do everything at once, and build your business plan on how you’ll meet the iden-

tified priorities. Let them drive your staffing patterns and your cost savings targets,” he says. “And make your program data-driven from the start.”

When Heroux started working with Lewis-Gale, they had none of these components. “They were trying to meet the needs without the infrastructure, and that is how they got into trouble,” he says.

Why are some hospitalist programs launched without this kind of support or the business planning that would be *de rigueur* for any hospital launching a new imaging center or outpatient surgery center? Perhaps the lack of capital investment on equipment for a hospitalist service leads to a casual attitude about doing the needed homework. Or else misconceptions blind hospital administrators to the real complexities and financial implications of a hospitalist program.

“I think there is a mentality sometimes that says, ‘Hey, we’re good managers, we can do this,’ ” suggests Heroux.

“Sometimes they don’t know what they don’t know. Many times they don’t want to spend the time and money or get the help [they need] to do it right.”

### **DO YOUR HOMEWORK**

Bruce Becker, MD, a family practice physician and chief medical officer at Medical Center Hospital in Odessa, Texas, spent two years helping his institution do its homework and gathering support within the medical community before the hospital’s board of directors approved a plan for a hospitalist program in July 2006.

“We started exploring a hospitalist program two years ago,” says Dr. Becker. A national company made a proposal to the hospital to develop a turnkey program. “We also attempted to work with private physicians and with the local medical school but couldn’t come to an agreement at that time.”

When the board was first approached with a \$100,000 proposal for a consultant’s study, it had the usual concerns

about return on investment and volume of demand, Dr. Becker says. But the biggest barrier to the new service was an attitude within the local medical community that hospitalists would disrupt continuity of care and longstanding relationships between physicians and their patients. To address this discomfort, “we decided to go step by step with our consultant—polling the medical staff, administration and board members,” says Dr. Becker. Their responses suggested that sufficient demand existed.

Dr. Becker asked a physician he knew who had set up a hospitalist program in another community to speak to the hospital board. He and several colleagues attended an SHM conference to learn more about the basics of operating a program. Eventually, the board approved a request for proposals (RFP), which was sent to seven potential contractors, both local groups and national companies.

“What we were going through was an educational process,” explains Dr. Becker. “I could see a visible change

taking place on the faces of board members. Two years ago, they weren’t ready, and if I had tried to push it, they would have said no. Now they are ready, and our medical staff is much more accepting.” Hospitalists are now being interviewed for the new program, with a projected launch date of July 2007.

### **THE IMPORTANCE OF LEADERSHIP**

Winthrop Whitcomb, MD, a practicing hospitalist at Mercy Medical Center in Springfield, Mass., and co-founder of SHM, believes the absence of strong practice leadership by someone with leadership and management skills who is based on site and devoted to hospital medicine is the number one reason why hospitalist programs fail. He tells the story of a hospitalist program started by a multi-specialty group that assigned as its medical director a primary care physician who had a busy office practice.

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“That leader wasn’t able to have much contact with the group or the day-in, day-out challenges of its growing caseload,” relates Dr. Whitcomb. “The hospitalists began to get demoralized, feeling that no one was advocating for them.” A consultant recommended hiring an on-site leader for the program. The next medical director had some knowledge of medical management and hospital medicine but was only one-quarter-time dedicated to the hospitalist program. Problems of morale, turnover, and service quality continued.

“The leader instituted a few good things, including an incentive-based compensation program, but ultimately was ineffective and unable to develop the staff’s trust,” says Dr. Whitcomb. “I could tell that story over and over again. To put it another way, a lot of the pitfalls can be overcome with a good, strong leader.” Often, programs such as the one he describes flounder but continue to limp along for years, until a good leader comes along to place the program on a stronger footing.

In other cases, a new hospitalist program might be

launched with just one physician and limited coverage, with plans to grow from there. “That’s fine, as long as that person you’re starting with is serving in a leadership capacity as well as seeing patients. It’s hard to find a good leader. But you will need somebody who is driving the bus in fairly short order,” says Dr. Whitcomb.

### GROWTH PAINS AND OTHER COMMON PROBLEMS

John Nelson, MD, a hospitalist and consultant in Bellevue, Wash., co-founder of SHM, and columnist for *The Hospitalist*, points out some other common causes of hospitalist program collapse, including the failure to appreciate how rapidly the program will grow or to have a plan for how to deal with growth. “It doesn’t take a year to reach your projections,” he advises. “Suddenly, you’ve got a bigger caseload than the original doctors can handle. They get overwhelmed and burned out and then leave.”

If the hospitalists feel no ownership or personal investment in the practice’s success, they may develop a kind of

civil service mentality about the job instead of a customer service mindset, says Dr. Nelson. Combine that with a straight salary instead of productivity incentives, and they may lack the necessary commitment to the program’s quality and growth.

“I also work as a consultant to help other hospitals start hospitalist practices. I’ve had a lot of experience with programs that never got off the ground,” he says. In one case, staff did an analysis to find out how much it would cost to support the program and then decided not to go forward. In that case, the hospital was reimbursed more on per diems than diagnosis-related groups, so reduced lengths of stay would not have benefited the facility.

In other cases, hospitals have not gone forward because of local medical politics or unfounded suspicions about hospital medicine. The dominant local multi-specialty group may insist on operating the hospitalist program itself, refusing to let anyone else do it. But the group makes unrealistic assumptions about workload or else wants to charge the same high overhead rate to the hospitalists that its clinic doctors pay, which is not feasible for a hospitalist program.

“I came to my current position because of a medical group that wanted to control the hospital medicine practice,” says Dr. Nelson. “But then they got busy and exhausted and wanted to quit being hospitalists. At that point, the hospital administrator panicked.”

### LEARN FROM SUCCESS

Thweatt believes that the hospitalist program at Lewis-Gale Medical Center, which now directly employs the hospitalists, is doing well, with seven full-time dedicated hospitalists. “Not that it’s always easy, but it’s no different than running any other business. If this program went away tomorrow, I think I’d be tarred and feathered by the medical staff,” he quips.

Dr. Patolia adds that the program has a compensation structure based entirely on productivity and a schedule that ensures 24-hour coverage. “We work as a team, and we depend on each other so much. We’re all committed people who want to be hospitalists,” he says. “Right now, I love being a hospitalist to such a degree that I can’t imagine doing anything else.”

Recently, a senior vice president from the hospital’s parent company, Hospital Corporation of America (HCA), visited Lewis-Gale to learn how to replicate its successful hospitalist program in all HCA hospitals.

Jon Ness, now chief operating officer of Billings Clinic in Billings, Mont., says one of the first things he did in his new job was to develop a hospitalist program. “I brought in Roger Heroux to do the evaluation,” he says. The process followed a familiar checklist: defining program goals, lining up clinic and hospital support, assessing manpower needs, and developing a data support system.

The Billings program was launched in January 2006 and today employs six full-time hospitalists. In contrast to the early days at Lewis-Gale, however, “we started out with a strong, deep business plan.”

For more information on the Fourth Generation hospitalist practice, contact Roger Heroux, Partner, Hospitalist Management Resources, LLC, 5490 Creighton Ct., Colorado Springs, CO 80918, 719/331-7119, or [rheroux@hmrllc.com](mailto:rheroux@hmrllc.com). Visit the Society of Hospital Medicine Web site ([www.hospitalmedicine.org](http://www.hospitalmedicine.org)) for information on practice management courses and other educational resources, including audiotapes of “Best Practices in Managing a Hospital Medicine Program.” **TH**

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