ILLINOIS CRITICAL ACCESS HOSPITAL NETWORK

RURAL HOSPITALIST STUDY

THE ADVENT OF HOSPITALISTS IN ILLINOIS CRITICAL ACCESS HOSPITALS: 2009

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RURAL HOSPITALIST STUDY
OUTLINE

I. Executive Summary

Physician recruitment imperatives and changing priorities of existing physicians will dictate that almost all critical access hospitals (CAHs) initiate a hospitalist program within the next ten years. At first blush, it would appear financially untenable for hospitals with less than twenty-five beds to be able to support hospitalists, yet several financially successful hospitalist programs exist in CAHs in Illinois and elsewhere. This paper will explore some of those models and identify common threads for success. Chief Executive Officers (CEOs) will also be provided with steps they can take to better position their hospitals on the assumption they will soon face the need to begin a hospitalist program.

II. What Is Driving CAHs To Establish Hospitalist Programs?

Two surges are converging on Illinois critical access hospitals, and the result will be enormous. First, primary care (for purposes of this Report: family practice and general internal medicine) physicians in private practice in rural areas are burning out. It may be that they are aging and are unable or unwilling to manage active and successful office practices while also covering their hospitalized patients at the beginning and ending of each day and throughout the night. It may be they are just fed up with a profession that requires them to be "on" forever with little or no let-up. It may be that financial incentives to treat hospitalized patients versus office patients have shifted in favor of office patients. It may be that the expectations of hospitalized patients have changed so that primary care physicians can never satisfy those expectations. Regardless of the reasons, primary care physicians in rural areas are throwing in the towel of managing their hospitalized patients. More and more, these primary care physicians are unilaterally announcing to their patients and to the local hospitals they will neither continue to take responsibility for hospitalized patients nor continue to "take call".

The second surge comes from the "doctors of the future". Simply stated, physicians now leaving residency programs are generally unwilling to take call and be responsible for hospitalized patients. With half of them female, there is an increased drive for them to seek a "real life" outside of the profession. Young physicians will likely run from any recruitment opportunity where the traditional model of "taking call" and managing hospitalized patients exists. Hospitals which have not significantly reduced the "after hours" physician responsibilities will find it very difficult to successfully recruit desirable physician candidates in the immediate years ahead.

These two driving forces will cause all hospitals to search for alternatives. In the end, the author believes that almost all CAHs will be compelled to introduce some form of hospitalist program in the next ten years. The trend is already wide-spread in larger hospitals across the country, while CAHs have generally been spared thus far. This is partly due to the fact that the most "country doctors" still hold tightly to the traditional vision of their professions. However, as these physicians age and as the need for

physician recruiting looms, CAHs will soon face major challenges to provide physician coverage for hospitalized patients.

What other incentives exist which might drive a CAH into a hospitalist program? While these other reasons to exist, no incentive appears as great as changing the attitudes of existing primary care physicians "retiring" from caring for hospitalized patients or physician recruiting. However, the following additional motivations have been cited:

> Physician contract groups also make claims that the introduction of a hospitalist program will increase the patient census by twenty to fifty per cent in the first year. Because of an obvious conflict of interests, data supplied by such firms is always suspect. However, one ICAHN member hospital claims the introduction of a hospitalist program has increased inpatient volumes by twenty per cent. The rationale is that this increase in patients is sufficient to off-set the additional costs of hospitalists. This hospital's program will be explored in greater depth later.
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> The literature, generally written by hospitalists, espouses that when hospitalists rather than a patchwork of primary care physicians take care of hospitalized patients, the quality of care is enhanced. The counter-argument is that primary care physicians who better know the patients, their families, and their medical and social histories, are better equipped to provide care to their patients. No compelling studies in the CAH setting have been put forth by either side that this author was able to find. However, there is truth in both arguments. If the primary care physicians already provide good quality medicine and are truly available to their patients and other caregivers and providers at all times, then the traditional model is likely superior in terms of quality. However, the skills of primary care physicians are sometimes not "cutting edge", and their availability is sometimes dictated by *their* schedules rather than their patients. .

Discussion with CAH CEOs who have implemented hospitalist programs tend to suggest that in most cases, the driving force behind consideration of hospitalist programs is an announcement from the primary care physicians that they will no longer assume responsibility for care of their hospitalized patients. Rarely are these announcements made without warning or clear signs. Often, primary care physician groups who are attempting to recruit new members come to the conclusion that they are unable to successfully recruit desirable candidates until the "on-call" expectations for the new physician are lessened or eliminated. In such cases, it is not unusual to see the senior members of the medical group reluctantly continue to be responsible for the group's hospitalized patients even when the newer group member refuse to provide those services. Obviously, this all has significant impact on the local CAH. When this happens, the spiral has been set in motion and will soon reach the point where the group's senior members will also drop out of the call rotation.

III. Discussions with Stakeholders

CEOs are caught in a difficult position when they sense a deterioration of the on-call rotation scheme. If they wait until the primary care physicians announce they are "throwing in the towel", then there is little time to formulate and evaluate options. In fact, there may be no options remaining at all other than to turn to an expensive contract physician firm that will provide hospitalists or intermesh hospitalists with existing emergency department arrangements. If decisions are made in the heat of crisis, the outcome likely may not be as palatable to the many stakeholders which the typical critical access hospital must satisfy. On the other hand, the CEO may sense that prematurely opening discussions among these same stakeholders may create unwanted and unintended signals sent to the primary care physicians and others and may, in fact, begin to drive the decision itself. It is a delicate position to assume and is even more complicated if relations among the major players are already strained.

There is also a question of scale. If only one of five primary care physicians ceases taking call, is there a solution short of initiating a hospitalist program? On the other hand, the hospital cannot wait too long. There is a "tipping point". Many CEOs and contract firms recommend that hospitalist programs need not wait for one hundred per cent of the primary care physicians to default to the hospitalists. In fact, several CEOs interviewed advised that the hospital should not attempt to force the hospitalists onto the primary care physicians who continue to take call and care for their hospitalized patients.

At least two ICAHN CEOs reported their hospitals have had serious and meaningful discussions with stakeholders including financial analysis before they decided not to proceed with a hospitalist program. The result of the discussion and analysis apparently has relieved the pressure to begin a hospitalist program, at least for the time being. It will be interesting to see how much longer they will be able to resist. More importantly however, this exercise has certainly been healthy for the organization and has allowed all parties to seriously consider how such a program might affect them and how such a program might be developed in those environments. One has to believe these discussions will later prove to have been very useful.

It is the wise CEO who has already led discussions with his or her governing body as to the trends toward hospitalists and possible scenarios which might unfold in the future. Boards never like surprises, and they certainly do not want to open the morning newspaper to read the local physicians have decided to quit seeing hospital patients. Assuming that a traditional hospitalist model would require at least 3.0 FTE hospitalists at $200,000 per FTE, plus another $150,000 in related expenses, it is assumed the knee-jerked reaction of the typical governing board member would be that the hospital is unable to absorb another three quarters of a million dollars a year in expenses. CEOs are encouraged to be talking with their respective governing boards about these trends well in advance of any activity in this area.

Hospitals that have launched successful hospitalist programs have almost always mentioned how sensitive are the public relations aspects of the decisions and the need for the hospital to manage the "PR message". Virtually every stakeholder has an interest that the message be delivered with a positive spin. For instance, the physicians do not want to be seen as selfishly abandoning their life-long patients. The hospital does not want the hospitalist program to be perceived as a crisis situation which will result in patients being seen only by out-of-town physicians who have no prior knowledge of the patient. Hospital employees have an interest that the message to the community be positive to prevent patient flight. Governing board members do not want to deduce that the added financial burden of hospitalists will be the "straw that broke the camel's back" for their already-burdened local hospital. Hospitals that are faced with the issue may be well advised to obtain the services and advice of a professional imaging firm to help manage the message so that everyone benefits, and so that fears among the hospital's constituents are reduced. CAHs are notorious for doing things themselves and not seeking outside help, but even really good decisions made regarding hospitalists can be completely wiped out by "bad PR". Yes, it's probably worth it!

IV. When to "Pull the Trigger"

Before looking at the financial costs, incentives, and disincentives, there are other issues which have to be considered. In many cases, the initiation of a hospitalist program is not purely an exercise of determining what options are financially and quality-wise best for the institution. Unfortunately, if the local physicians announce publicly they will cease to go to the hospital to care for their patients at the end of the month, management, the governing board, and the community face a real threat to the very existence of the facility. It's not then a question of the best financial option to maximize income, but it has become a matter of survival. In some cases, this scenario is exactly what was faced by CAHs.

Fortunately for most hospitals, open communications prevail. Increasingly, hospitals and medical groups come to the conclusion they are not going to be able to recruit new physicians without the existence of a hospitalist program. Physician recruiters for small rural hospitals are increasingly concluding that the time is fast approaching when it is no longer possible to recruit primary care physicians to rural communities when the local hospital does not have an active hospitalist program.

Another scenario discovered is that the hospital realizes that the local primary care physicians are admitting fewer and fewer patients to the CAH. When interviewed, primary care physicians may report that they are not reluctant to care for hospitalized patients, but rather they feel their patients would be better served if, when they needed to be hospitalized, they were referred to a specialist in a town "down the road". Even CAHs with wholly-owned medical practices sometimes awake to the realization this is happening in their relationship. The primary care physicians may not be consciously sending their patients elsewhere because of the lack of a hospitalist, but the effect is the same.

Hospitals cannot exist without physicians admitting and treating patients. Some CEOs may look at their respective situations and conclude that the creation of a hospitalist program is a "deal breaker" which may singly determine if the hospital can continue to exist. If that conclusion is reached, then the issue defaults to "What can we do to mitigate the additional costs?"

Many CEOs who are not "under the gun" will approach this decision like they do all other decisions with financial implications, "Will the financial gains off-set the expenses?" Others have found themselves facing a binary decision, "Is my hospital going to stay open or is it going to close?" It is the wise CEO who leads the discussion in a positive way before the options become limited to the binary.

V. Findings from the Field: Member Interviews, 2009

The Illinois Critical Access Hospital Network (ICAHN) is composed of fifty critical access hospitals. All CAHs in Illinois are members with one exception. In March and April, 2009, a survey was conducted of the members to determine which had some form of hospitalist programs. The term "hospitalist" was purposefully not defined. Of the fifty members, forty-three participated (86% response). Of the remaining seven hospitals, ICAHN staff had no knowledge of the existence of a hospitalist program.

Of the members, eight (16%) reported having a "hospitalist program". At least fifty per cent of the hospitals surveyed reported they are very interested in the result of the survey as they are or expect to soon be evaluating a hospitalist program for their hospitals.

Telephone or face-to-face interviews were then conducted with the CEOs or senior managers of each of the eight hospitals which reported a hospitalist program. More detailed summaries of each of these interviews are attached to this document as exhibits. Efforts have been made to protect the identity of each hospital.

A. Models

The traditional definition of a "hospitalist" is "A physician who works exclusively with hospitalized patients …" However, like in other areas, CAHs display a wide divergence in their definitions of the term. The main models identified in Illinois CAHs are as follows:

Pure Hospitalist: The hospitalist is exclusively dedicated to the care and treatment of inpatients. Some variation may exist in that in one example, a plan is being assembled to share the hospitalist between two neighboring hospitals. In another example, the hospital pays two members of its medical staff to assume care for unassigned inpatients. Describing this latter arrangement as having "hospitalists" may be a stretch because they are not in the hospital around the clock, yet these physicians assume responsibility for inpatients. The question

centers on "exclusivity". In no case was the researcher able to find an Illinois CAH using a pure hospitalist model with the hospitalist exclusively treating inpatients.

Hospitalist/Emergency Department (ED) Physician: In this model, the hospitalist is responsible to treat inpatients and ED patients. This model is most often found in Illinois CAHs.

Hospitalist/ED/Clinic Physician: In this model, one physician is generally present in the hospital and responsible for care of inpatients, ED patients, and staffing a hospital-owned clinic located in the hospital. In one situation, the physician was responsible for inpatients, ED patients, and provided medical supervision of physicians' assistants in an adjoining rural health clinic which was open sixteen hours per day.

The interviews revealed that there is certainly not "one size fits all" solution. No two programs looked the same, yet those CEOs with hospitalists are remarkably satisfied with their current arrangements and openly expressed that the use of hospitalists has improved the quality of care and enhanced their ability to recruit physicians. Readers are encouraged to review the summaries of the interviews to understand the wide diversity of programs in existence.

B. Origin of Hospitalists

Physicians who assume the role of hospitalists in Illinois CAHs came from two sources. In some cases, they are employed or are independent contractors of physician groups like "Acute Care", "AIMS – All-Inclusive Medical Services", "Hospital M.D.", "Hospital Care Consultants", "Cogent", "EmCare", or "Apogee". In Illinois CAHs, all physician groups which were used to provide hospitalist services combined at least hospitalist and emergency department coverage. In most cases, when the CEOs determined they needed to introduce hospitalist services, the logical solution was to turn to their existing ED physician group to learn if that group's physicians could and would also assume hospitalist responsibilities. In at least two cases, the hospitals actually ended their relationships with existing ED physician groups in order to contract with new groups that provided an expanded scope of services. The advantages to using an outside group for hospitalist services are identical to advantages in using an outside group for ED coverage, i.e., back-up services, ability to more easily substitute providers, availability for additional opportunities for continuing education of physicians and staff, databases for quality, revenue enhancement, etc. The biggest drawback, however, is that outside groups are usually more expensive.

The other option for securing hospitalist services is for the hospital to directly contract with physicians. In some cases, the two or three physicians who serve as hospitalists are the hospital's only contract physicians. However, in most cases where hospitalists exist, the CAH may obtain hospitalist services from a "pool" of primary care physicians who are also involved in a hospital-owned clinic(s). In one case, the

hospitalist was one of seven physicians who provided services from a hospital-owned clinic. The advantages of the hospital to contract directly involve local control and lower expenses, generally. The disadvantages have to do with the isolation of the physicians themselves for continuing education and quality stimulation. Clearly, physician groups have the ability to bring value-added components to the hospital, but these can often be duplicated by the CAH.

The ICAHN member survey located a hospital which contracted directly with two of its already existing primary care physicians to assume responsibility for unassigned inpatients. Because these physicians performed these services on a part-time basis and have only limited availability to the patient, this arrangement does not fit the "hospitalist" definition. This arrangement has solved the problem of primary care physicians being responsible for inpatient care of unassigned patients, but it does not completely solve the problem of the rest of the staff taking care of their inpatients. Physicians being recruited would presumably, be required to "take call" for their patients. This arrangement appears to have temporarily solved the most immediate "call" problem of one Illinois CAH. The interview with this CEO is summarized in "Summary of Interview with CEO #4".

C. Finance

Detailed and exhaustive financial modeling is best left to the accountants. Those who approach the question of how to financially justify the introduction of hospitalists will likely be disappointed. Several hospitals, however, report that their hospitalist programs actually have generated revenues in excess of corresponding expenses. Most hospitals, however, report that the decision to introduce hospitalists is part of a bigger package involving the emergency department and, often, their clinics. In most cases, the revenues and expenses associated with hospitalists are usually substantially intertwined with those of the ED and clinics. But, there are financial considerations that can be identified and which deserve consideration.

Hospitals contacted for this project were reluctant to divulge actual expenses. In many cases, their contracts with physicians or with contract agencies prohibited disclosure of financial information. However, we can draw a few conclusions and expect not to be far from accruate.

1. Revenue Side

On the revenue side, several CEOs interviewed said with the CAH being paid based on costs and professional fees established by a different reimbursement formula, the goal is to explore reimbursement options in an effort to attempt to generate as much revenue as possible to off-set the expenses of the program. The breakdown of the physicians' time will likely determine the way to approach reimbursement. For instance, member interviews revealed examples where the physician devoted half of his time seeing patients in a hospital-operated clinic, another ten per cent supervising a rural

health clinic, another twenty-five per cent treating patients in the ED, and the last fifteen per cent serving as a hospitalist. In another hospital, the contract provided that the ED/hospitalists were to divide their time seventy/thirty per cent. The savvy physician and CEO will look at each of these roles played by the physician and then determine the payers in each case before establishing a reimbursement strategy. In the end, many CEOs commented that the most important element of the reimbursement piece for physicians in these multiple roles was the creation and diligent on-going attention to time records. The worst scenario is for a physician to complete a twelve hour shift with a time sheet that only adds up to eight hours.

The quest to maximize revenue can be very complicated. One of the advantages for a CAH to use the services of a physician group is that often these groups provide counseling to improve coding and maximize reimbursement. The CEOs revealed that in most cases when contract groups were used, the contract provided that the group retained fees generated for the physician's services, i. e., "professional fees", leaving the hospitals to pay a stipend for the service. One could develop a whole paper on the advantages and disadvantages to this, but suffice it to say that the physician groups that keep the professional fees have very excellent physician time records, coding, and physician "buy-in" with the process. For those hospitals that do not contract for physician services, they need to as much as possible emulate programs related to reimbursement which have proven to be so successful for the physician groups.

In the course of the interviews, several CEOs discussed strategies they used to improve reimbursement. Because each situation is so different, this Report we will not provide any detail here, but recommend that any hospital that has a "home grown" hospitalist program would likely benefit by the advice of a coding and reimbursement consultant coupled with a rigorous and exhaustive effort to improve the revenue cycle..

Another revenue consideration was identified by two CEOs in the interviews. As their hospitals were evaluating whether to move a physician from the clinic to a hospitalist position, consideration was given to increasing clinic hours because clinic physicians would no longer need to "round" on inpatients each morning and evening. The hospital and clinic concluded that the additional clinic visits made possible by the extended clinic hours off-set the additional expense for the compensation of the hospitalist. However, when the clinic and hospital are owned by different entities, then incentives are different and problematic in this case.

2. Expense Side

On two occasions when the interviewer asked about the additional expense of a hospitalist, the CEO reported there were no additional expenses simply because the ED physician was recruited to also take care of inpatients.

Hospitalist programs generally have identifiable costs. In the purest hospitalist model, a physician would be present in the facility and dedicated to services for inpatients twenty-our hours per day. In order to achieve this round the clock coverage, at

least 3.0 FTEs will be required with another FTE most likely. According to a survey[i] conducted by "Today's Hospitalist", in 2007, the average total compensation for hospitalists was $190,923. The active hospitalist who was surveyed agreed this was a reasonable amount to calculate for a CAH in a rural Midwest setting. The figure of $200,000 rounds nicely for our purposes. Given that, physician costs would amount to ($200,000 X 3.0 =) $600,000. Of course, the wise CEO would build incentives into the compensation to encourage productivity, compliance with quality and other goals, participation in meetings, etc. Adding another $100,000 per year to the formula would not be unreasonable to amortize recruiting expenses, pay for additional training of personnel related to coding and reimbursement, and other expenses related to the advent of a hospitalist program. In some cases, the hospital may even have to construct offices and "ready room" facilities for the hospitalist. In the end, it would be the rare CAH that could begin its own program for less than $700,000 per year.

Another option for a hospital would be to contract this service out to a physician group. Determination of the financials for this option becomes more difficult, especially if the group retains reimbursement for professional fees. However, it is assumed that expenses for a physician group will be greater than if the hospital sets up its own internal "group" to provide this coverage.

Given an additional annual expense of more than $700,000 and reimbursement of less than half of that amount for the typical CAH, the author and others have come to the conclusion that operating a pure hospitalist model in a CAH is financially untenable. Of course, operating such a program in the short term may be required to maintain the existence of the institution. One member hospital CEO reported that the staff at this hospital had conducted exhaustive evaluation of the possibilities associated with introducing a "pure model" hospitalist program and concluded it was not financially feasible. For political and other reasons, they did not opt for the possibility that the hospitalist would spread his or her time to the ED or to clinic services. Without being able to spread out physician's hours, the financials simply could not work.

Another issue a CEO needs to take into consideration comes from the literature and is backed up by several field interviews. If the hospital ancillary staff is not used to having a physician in-house around the clock, stress points in a new program will likely occur in the lab and in radiology/imaging. In both cases, these departments are not used to being expected to complete studies and/or tests while the physician may stand a few feet away awaiting results. One CAH reported the switch to a hospitalist also required both lab and x-ray to become "twenty-four per day departments". This, of course, could result in additional expense.

D. Physicians' Time

One question which surfaced early in the study had to do with the relationship between the size of a typical CAH and the amount of time required for a hospitalist to provide high quality services.

A hospitalist located at an Illinois CAH who was interviewed said that the typical hospitalist is able to comfortably be responsible for twenty to thirty acute inpatients. With the size of CAHs, there is obviously a mismatch between physician time supply and demand. Data from the 2006 Flex Monitoring Team Performance Study[ii] showed that in Illinois, the average CAH had an average daily census of seven acute patients and two swing or skilled nursing facility-level patients. In other words, the average daily census for these hospitals was about nine patients.

One interviewed CEO provided especially insightful information. At that facility, in each twenty-four hour period, the physician typically sees ten patients in the ED, another seven or eight acute and another six swing bed patients and still recorded seventy per cent of the time was "down time", according to the physicians' own time logs.

A second CEO reported the physicians at his facility on each day typically see one or two acute patients, seven or eight swing bed patients, four to five ED visits, and another sixty to seventy clinic patients. Of course, the CEO of this facility also admits the number of clinic visits has reached the point where he will soon need to recruit a second physician.

A third facility reports that each twenty-four hours, the ED/hospitalist sees fifteen ED patients, seven acute patients, three swing bed patients, and three observation patients.

Clearly, with the right financial and other incentives, physician productivity can be enhanced.

E. Additional Considerations

1. Community reaction and perceptions

In each case where a hospitalist program was introduced, we asked the CEO to address changing community perceptions. In each case, CEOs said they had some concerns about this, but their concerns proved later to be largely unfounded. They all believed the introduction of hospitalists had improved their hospitals' image in the community. In three cases where the introduction of the hospitalists also involved a change in ED physician coverage, they said they received significantly improved community reviews because the hospitals' reputation in the community previously had suffered due to mid-level practitioners providing coverage in the ED.

Several CEOs reported that the key is for the primary care physicians to explain to their patients exactly how the new program works and how it would effect them if they were to be hospitalized. In the case of one CAH, the hospital's marketing department produced a brochure which described the hospitalist program and made sure copies were provided to the waiting rooms of all physicians who routinely turned care of their hospitalized patients over to the hospitalists. The objectives of this early patient education effort are to make the patient more comfortable with the program, enhance the

image of the hospital, and for the primary care physician to explain why he or she has decided the patient is best served by the hospitalist.

2. Back-Up Services:

Some of the hospitalists described in the interviews were borderline "Supermen", given the fact that they functioned as hospitalists, ED physicians, and clinic primary care physicians. When the pool of physicians in the community is so thin and the scope of responsibilities so great for some, inevitably, the question arises as to where these physicians go for back-up when disaster or illness strikes. One CEO reported he had recently signed a contract with a physician group primarily so that better back-up could be assured. Based on the interviews, most CAHs had carefully laid out plans to provide for additional immediate support, primarily to the ED. In one hospital, the members of the active medical staff remained on a call rotation for back-up that was rarely used. In others, especially with an active primary care clinic down the hall, the threat is not so great. One CEO reported that his hospital had no formal system established, but that the local physicians came when the call went out. In some cases, the availability of mid-level practitioners was noted. Regardless of the method employed, there is an obvious need for a reasonable back-up system.

F. Quality Quest

Virtually every CEO with a hospitalist program who was interviewed said he or she thought the quality of patient care was enhanced by the hospitalists. However, these same CEOs also admitted they had no empirical evidence to support that claim. In a on-line presentation made by Alan Himmelstein, FACMPE, President of Hospital Care Consultants, Inc. on February 25, 2009[iii], Mr. Himmelstein provided information showing a fourteen per cent reduction on "cost per case", reduction of medical errors, and a sustainable reduction of inpatient length of stay, readmission rates, and in-hospital mortality for hospitalists over the traditional hospital care model. However, it is not clear which, if any, of these findings are relevant or achievable in a CAH environment. He then went on to describe other similar achievements in an eighty bed hospital in rural Oklahoma.

Some CEOs believed that if there are fewer physicians taking care of patients in the inpatient setting, the amount of variation would be reduced, thus resulting in improved quality. Another said the average length of stay for hospitalists was considerably lower than for non-hospitalist physicians. With a decreased ALOS, the nosocomial infection rate is reduced, thus quality of patient care is increased.

Another CEO reported that with the advent of hospitalists who are likely younger and more recently trained than the existing medical staff, the "bar has been raised". The hospitalists were seen by the CEO as being more aggressive with treatments and better able to use the cutting edge tools available at the hospital.

The hospitalist interviewed said that over time, the hospitalists begin to assume more control in the treatment of not only their patients, but significantly influence the treatment of other patients either directly or indirectly. Assuming the hospitalist practices high quality medicine, it is thought positive changes would occur in patient care across the board.

Hospital CEOs are constantly admonished that quality of care has two components: clinical outcomes and patient satisfaction. Clinical outcomes for CAHs using hospitalists have little statistical support at this point, but hospitals are quick to explain that patient satisfaction has increased. One example is manifested by the frustration that patients' families feel when they wait at the patient's bedside hoping to "catch the physician". When the physician appears to be available only for what is perceived to be fleeting seconds in the early morning hours then after the office closes in the evening, frustration often abounds. Increased availability of the hospitalist will eliminate this patient/family frustration.

Several CEOs surveyed expressed concerns about the clinical training and skills of some physicians who undertake these multiple roles. In two cases, the CEOs have gone out of their way to state that the skills required for a good ED physician are different than those required by a hospitalist, especially when the bulk of the hospitalists' patients in a rural CAH is care of geriatric patients with complications of chronic illness. One CEO whose hospitalists also work in the ED stated his hospital requires the ED physician group to provide only physicians who are board certified in both emergency medicine and a primary care specialty. He admits these prerequisites drive up the cost, but thinks this requirement makes sense. It is also noted this hospital is within comfortable driving range of Chicago, where members of the physician group reside.

In the end, the selection of the physician to serve as hospitalist is paramount. A physician with good training, skills, and clinical outcomes coupled with a personality that is able to reach rural patients in a positive manner is the greatest asset. Single-handedly, a shining "super-doc" can greatly enhance the image of the hospital in the community. On the other hand, a physician who has clinical and/or personality issues can quickly do irreparable damage.

Interestingly, interviews with CEOs who have hospitalists revealed that the provision of hospitalists seems to improve the relationship between the hospital and the medical staff. All eight of the hospitals with hospitalists described unusually positive harmony between the primary care physicians and the hospital. Admittedly, most of the hospitals who reported a hospitalist program also operate hospital-owned clinics, and it is assumed that most of the physicians are employees of the hospital.

VI. Profile of a Hospitalist

Today's Hospitalist magazine conducted its 2008 Hospitalist Compensation and Career Survey[iv] which provides information about hospitalists across the country and through the Midwest. However, because only eleven per cent of the hospitalists

surveyed worked in hospitals of less than one hundred beds, the relevance of this information to critical access hospitals is marginal. Nevertheless, the trends shown by the Survey are important and may provide some guidance to the CEO.

Total Compensation: The average total compensation for hospitalists in the U. S. in 2007 was $190,923. The only medical specialty shown in the survey that reported lower compensation was "general pediatrics" at $147,051. In the same survey, "Med/Peds" specialists received $193,786, family practice received $194,111, and general internal medicine received $196,571. Total compensation for hospitalists was highest in the Southwest at $198,634 and lowest in the Northeast at $171,361. The Midwest average was $197,543.

Compensation Arrangements: Sixty per cent of the hospitalists surveyed said their compensation consisted of a mix of salary and bonuses and incentives. Thirty-four per cent reported "salary only" and only six per cent reported only "pure productivity". When asked about the details of the "bonuses and incentives", those hospitalists in the Midwest reported that the most common elements were "quality measures" (satisfaction scores, guidelines, medical documentation), "committee work", and "production" (number of admissions, shifts worked, relative value units, admissions).

Fringe Benefits: Eighty per cent of the hospitalists reported their employer provided them with "tail coverage" for professional liability insurance.

It is not clear how many hospitalists in Illinois CAHs identify with the national hospitalist group and participated in the survey, especially if they are also responsible for the ED and clinics. The Survey can be reviewed on-line at www.todayshospitalist.com.

VII. Parting Words from the Trenches: CEO to CEO and Conclusion

A. Parting Words

The following is a stylized compilation of "Parting Thoughts" from CEOs with hospitalist programs:

On making the decision: "Each hospital needs to look at its unique situation. With low patient volumes, we could never afford the traditional hospitalist program."

"Quit worrying about dollars and cents but look at the big picture of patient and medical staff satisfaction". Medical staff/hospital collaboration has never been better. "If you have a good handle on the revenue cycle, then there will be money there to make it work". "Controlling the revenue cycle" is critical.

"Listen to your docs". They will support the introduction of a hospitalist program simply because this is now a prerequisite to recruit new physicians. It is also about the only way to convince specialists to come to small rural communities.

"Make the medical staff feel they are treated no differently than if they were not hospital employees. They need to be involved in discussions and decisions"

"Do not begin the search for a solution with a specific model in mind. Keep an open mind so you can recognize unusual opportunities which might present themselves".

"The small volumes at a CAH dictate that the hospital use our model (hospitalist/ED/clinic). For us, there is no other choice."

"To really understand the problem, one has to look at the patient transfers to understand what kinds of patients are going out the door. We have the ability to take care of many more patients than were coming here, but we were not seeing large numbers of patients because their local family physician here in the community was not willing to accept inpatient care for the patient".

"Look at patient origin studies at neighboring hospitals. How many patients from our community are going there? How many patients have changed doctors over the years because they are not sure who would take care of them if they needed to be hospitalized?"

"Let the physicians make the decisions about call --- you can create a good hospitalist program, but you can't force it on them". Do not overly pressure the primary care physicians to use the hospitalist.

On the program's operations: "Having the doctors maintain accurate and defendable time logs is critical".

"The key to the success of this program is a consistent and small set of doctors who the contract group rotates to the community".

On the quest for quality: Having hospitalists has "raised the quality bar" for this hospital.

"Look at the future of healthcare quality. It's all about reduction of variation. When there is one hospitalist, there is less variation."

On collateral benefits**:** Having hospitalists will allow this hospital to recruit more primary care physicians in the future. "Without hospitalist coverage, physician recruitment would likely be nearly impossible"

"Because we have a hospitalist, we may have averted a couple of primary care docs from taking an early retirement".

"There is no way we could or would ever want to go back. The place would just implode on itself."

B. Conclusion

In the summer of 2008, one of the ICAHN CEOs posted a message on ICAHN's CEO listserv as follows:

> *Dear Colleagues,*
>
> *Today, I had my second active staff, primary care physician in the past 12 months inform me she is dropping active staff privileges and moving to consulting/courtesy staff. She is not employed by the hospital so there is not an employment contract issue to put forth as a deterrent.*
>
> *Her reasons are not unique as she explained that her practice is growing more and more, she doesn't admit many patients to our facility, her patients needing admission are too complex for us to handle, it's 15 miles from her office to the hospital to care for 1 or 2 inpatients, her days are longer and her personal time is shorter, etc.…*
>
> *Any others experiencing this phenomena and any ideas as to what you are or may do?*

About thirty fellow CEOs responded in differing ways. The Genesis of this Study and Report likely came from the responses of a couple of CEOs who said they had successfully initiated hospitalist program.

Clearly, hospitalist programs are here to stay. Clearly, the trend will grow and may actually save the lives of many fragile CAHs. There are a few very successful examples of hospitalist programs in Illinois CAHs. CEOs would benefit from learning how these successful examples work, start educating their governing boards and medical staffs, keeping an "ear to the ground", and maintaining an open mind when looking at hospitalist options.

This research produces several questions about the most efficient use of scarce health resources. The introduction of hospitalists in many hospitals most likely does not significantly increase productivity of the healthcare system, it only adds the additional cost of the hospitalists. While the author appreciates these concerns from a macro view of healthcare, we must, by necessity, yield to the more practical and immediate problems being faced everyday by CEOs. In a nutshell, CEOs need to reach a conclusion about their ability to recruit physicians without a hospitalist program.

There are two over-arching conclusions to this research.

First, if it holds true that CAHs are not going to be able to recruit primary care physicians in the future without having hospitalists, then hospitalists are needed. Next, if the only hospitalist programs in CAHs which are financially successful are the result of the merger of hospitalists and emergency department physicians or hospitalists and hospital-owned clinic physicians, then CEOs need to develop a strategy to move toward one of these two models.

The second conclusion comes also as a concern. If the future holds that each CAH across the state will be required by necessity to have hospitalists, then Illinois is going to need another one hundred fifty hospitalists to meet this need. When one evaluates the logical pool of physicians who might settle in rural Illinois as hospitalists, then there are far from enough candidates to fill all of the positions. If a hospital's survival depends on its ability to recruit primary care physicians and if the ability to recruit primary care physician hinges on the existence of a hospitalist program, then the critical path and focus changes from the need to recruit primary care physicians to the more immediate need to establish a hospitalist program and recruit the physicians to staff that program. Simply stated, there is a significant supply and demand factor at work here, and demand will far outpace supply. This may well be the greatest challenge for CAH CEOs in the years ahead.

VIII. Acknowledgements

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Alan Himmelstein, FACMPE, President, Hospital Care Consultants, Inc.

Today's Hospitalist magazine, www.todayshospitalist.net

Flex Monitoring Team, www.flexmonitoring.org

IX. Notes

i.. "2007 Hospitalist Compensation", Today's Hospitalist", www.todayshospitalist.net/08_salary_survey/

ii. "Statewide Graphs of Hospital Performance", State Level Data, Financial Indicators, Flex Monitoring Team: University of Minnesota, University of North Carolina at Chapel Hill and University of Southern Maine, Report Produced: Summer 2008, www.flexmonitoring.org/indicators.shtml.

iii."Hospitalist Medicine: A Primer for Senior Management", Alan Himmerstein, FACMPE, February 25, 2009, Video conference/WebEx Call, facilitated by Rural Health Resource Center, Duluth, MN, www.ruralcenter.org.

iv. See Note 1 above.

Additional on-line resources available to CEOs are as follows:

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Greensway, Deborah, "Can Hospital Medicine Save Medical Care in the Heartland?", *Today's Hospitalist*, www.todayshospitalist.com/index.php?b=articles_read&cut=45

"Rural Doctoring: Small-town Medicine in the Internet Age", *Rural Doctoring*, July 8, 2008, www.ruraldoctoring.com/2008/07/rural-doctoring-part-three.html

Dyan, Stella, "Wanted: Small-town Hospitalists", Internal Medicine, 2009, American College of Physicians, www.acphospitalist.org/archives/2007/12/cover_story.htm

Lindenauer, Peter K., M.D.; Michael B. Rothberg, M.D., M. P. H.; Penelope S. Pekow, Ph. D.; Christopher Kenwood, B. S.; Evan Benjamin, M.D.; and Andrew Auerback, M. D., M. P. H.; "Outcomes of Care by Hospitalists, General Internists, and Family Physicians", *The New England Journal of Medicine*; December 20, 2007; http://content.nejm.org/cgi/content/abstract/357/25/2589

Thrall, Terese Hudson, "Hospitalists: A Specialty Coming Into Its Own", Hospital & Health Networks, http://hhmag.com/hhnmag_app/jsp/printer_friendly.jsp?dcrPath+AHA/PubsNewsArticle/d

X. Exhibits

A. CEO Interviews

The following are summaries of interviews conducted between March 30 and April 27, 2009. The content of the summaries has been edited to protect the identities of each interviewee, hospital, or community.

SUMMARY OF INTERVIEW WITH CEO #1

Hospital #1 has had a hospitalist program for five years. Prior to that time, mid-level practitioners staffed the ED, patient satisfaction was low, and local primary care physician groups were finding it nearly impossible to recruit new, younger physicians because they were resistant to taking call and being responsible for hospitalized patients. The Hospital's response was to contract with an ED physician group which would provide one ED/hospitalist physician at all times. In actuality, the physicians each work 48 hour shifts. The group is headed by a local physician who then obtains the rest of the practice from physicians who reside in Chicago. The hospital requires all of the physicians to be board certified in both emergency medicine and in either family practice or internal medicine.

In this community, with only one exception, all primary care physicians are employed by the hospital. The only primary care physician in the area not in the group will be retiring later this year.

When the hospitalists were first introduced, there was some stress on existing ancillary departments because those departments were not operating round the clock. In the end, both lab and x-ray had to be converted to twenty-four hour operations.

When asked about community acceptance of hospitalists, the interviewer suggested that rural elderly patients in particular would not want to be "abandoned " by their family doctors then seen by a new face from Chicago. The CEO said they have faced no significant problems in this regard. Part of this is due to the fact that the family practitioners have been good to prepare each patient for the fact the patient will not be seen by the family physician if the patient is hospitalized. Further, he said the hospitalists have been very good about introducing themselves to the patient when admitted and alleviating problems.

The CEO said he believes the advent of the hospitalist program positively impacts the quality of care. He said the average length of stay has decreased as a result of the hospitalists, and that causes the incidence of nosocomial infections to go down, thus improving the quality of care.

When asked about relationships with specialists, he said he believes that many of the specialists who come to the community would not do so unless there were hospitalists.

For instance, he was successful recently in convincing an orthopedic surgeon from a nearby larger town to come to the community one day a week and perform surgery on his patients at the local CAH. Because the surgeon is unwilling to return to see the patient post-operatively, the hospitalists take over care of his patients. He said without this linkage, he doubts that they would be able to recruit any surgeons. They currently have two general surgeons, a urologist, and an orthopedic surgeon who turn care of their post-op patient over to the hospitalists.

When asked what advice he would provide to other CEOs, he said "Listen to your docs." He said they will support the introduction of a hospitalist program simply because this is now a prerequisite to recruit new physicians. It is about the only way to convince specialists to come to small rural communities.

SUMMARY OF INTERVIEW WITH CEO #2

Hospital #2 encompasses a CAH and a federally designated rural health clinic which is located within the hospital. The clinic is largely staffed by a physician's assistant. The hospital does no surgeries or obstetrics.

Five or six years ago, the hospital determined it could not continue staffing its ED with PA's. When the PAs wanted to transfer patients to other facilities, the specialists at these facilities often were unwilling even to talk with them. They were also losing local patients to other hospitals because the local doctors sometimes did not want to be responsible for providing care to inpatients, either acute or swing beds. The hospital responded by deciding to employ ED physicians round the clock. From the beginning, the contracts between the hospital and the ED physicians stated that the ED physicians were expected to provide ED coverage, take care of all acute and swing bed patients who presented without a local doctor, and back up the PA in the clinic which was adjacent to the ED and open sixteen hours per day.

Currently, the ED/hospitalist position is staffed primarily by two physicians who sign on for about three hundred hours each per month. They work a shift of twelve or twenty-four hours. Besides these two, local primary care physicians fill in the remaining slots left vacant by the others. The CEO reports they have never had trouble obtaining enough physician hours to complete the schedule. It is not uncommon for an ED physician working 300 hours per month to receive annual compensation in excess of $300,000. The two main physicians in this rotation both worked previously for ED contract groups.

CEO #2 said in a typical twenty-four hour period, the ED physician/hospitalist will see ten patients in the ED, another seven or eight acute patients, and another six swing bed patients. Even with this, according to time logs they maintain, about seventy per cent of their time is "stand-by".

From a financial point of view, this arrangement costs the hospital the same as it would if they staffed the ED twenty-four hours per day. However, with an average of only ten visits per day (average 350/mo) in the ED, providing full-time ED coverage would be untenable. When the ED physician admits the patients, there is an issue to determine if professional component reimbursement would be greater for the ED visit or for the acute inpatient admission. Because of regulations, the same doctor cannot bill for both.

The CEO reports that the public seems to have accepted this arrangement as it has been in effect for the past five years. The only complaint heard is that some patients do not like being seen by so many physicians. If a patient is in the hospital three days, the patient's care may be managed by three different physicians. The secret is that the ED physicians/hospitalists must communicate well with each other.

The hospital has no specialists on its active medical staff.

One of the two primary ED physicians/hospitalists recently moved to a house three doors down from the hospital. This physician is permitted to go home for lunch and other brief periods when not busy. "Even with being down the street, he is able to respond to the ED faster than doctors in a major medical center who come from doctor's ready rooms", commented the CEO.

The hospital permits patients to be seen in the ED by their own family physicians. When this occurs, in almost all cases, the family physician then continues to care for the patient after admitted. The hospital had taken the position not to object to this arrangement with the expectation that the family physicians who prefer this will soon retire or change their minds about it.

When asked about recruitment, the CEO replied they had no specialists on the staff. The CEO recruited the two ED doctors, but one actually recruited the other. Both had worked for the same ED group before coming to the community. CEO #2 said he has had no problem recruiting but admits it has been several years since they needed to recruit a physician.

When asked about what information the CEO wanted to pass along to other CEOs, CEO #2 recommended that each hospital needs to look at its unique situation. The CEO said that with low patient volumes, the CAH could never afford a traditional hospitalist program. Further, the CEO said having the doctors maintain accurate and defendable time logs is critical. In the end, with the hospitalists having an average of thirteen hospital patients, they spend less than two hours per day seeing these thirteen patients.

CEO #2 agreed that having hospitalists has reduced the average length of stay. The CEO also cited instances where having the hospitalists has "raised the quality bar". The CEO identified where having a hospitalist has created some friction between the hospitalist and both nursing and ancillary departments.

This hospital's culture is much more relaxed than the typical hospital. When queried about a back-up arrangement in the event the ED physician/hospitalist becomes overwhelmed, the reply was that other local physicians and the PA from the clinic will respond – "nothing formal". It is thought this informality has contributed to the hospital's ability to accomplish much with fewer physicians than most hospitals experience.

SUMMARY OF INTERVIEW WITH CEO #3

Hospital #3 operates four primary care clinics. With only one exception, all of the medical providers in the community are employed by the hospital.

The clinics are staffed by three full-time physicians and one part time physician along with several mid-levels. There is a full-time general surgeon and an OB/Gyn who is also employed by the hospital.

A couple of years ago, members of the clinic began to rotate weekend call, and the doctor on call then took care of all of the clinic's patients who were in the hospital. Since almost all patients were from the clinic, effectively, the doctor with weekend call became the *de facto* hospitalist. A year ago, one of these physicians took an unexpected leave of absence, and the need for another doctor to join the clinic appeared. A physician from a much larger Illinois city was recruited by the hospital. The new physician had previously served as a hospitalist and had extraordinary experience in that role. He was also aged in his fifties and had a very strong work ethic. Once he arrived, the other members of the clinic staff felt it best to defer more and more hospitalist care to him. Because of the advent of the hospitalist, they are able to start seeing patients in the clinic one hour earlier each morning. Since January, 2009, the hospitalist has been responsible to see patients in the clinic only in the afternoons. In the mornings, he "rounds" for all of the clinic's inpatients. He then assumes responsibility for the clinic's patients through the night. All members of the clinic physician staff share call rotation for weekends, including the hospitalist.

While the hospital also has an employed OB, the hospitalist does not assume inpatient care for these patients. However, in many cases, the hospitalist assumes care of the new-born when other arrangements have not been made.

The hospital reports no problems resulting from the advent of the hospitalist program relating to nursing or the ancillary departments. The hospitalist has extraordinary patient and staff relations skills.

Because the clinic has rotated its inpatient coverage on evenings for years, patients have already been used to possibly be having a different physician when admitted than the family doctor. Community acceptance has also been enhanced simply by the friendliness

of the new hospitalist. He has gained many new patients because of his high profile caring to hospitalized patients.

Patient volumes are not great enough to justify a full-blown hospitalist program. The ED physicians are a separate group and are not very busy. They have a good history of helping the hospitalist when needed.

When asked for "parting words", the CEO suggested it was important to make the medical staff feel they are treated differently than traditional employed physicians. They need to be involved in the discussions and decisions affecting their practices and the hospital. Secondly, the CEO urged peers not to go into the search for inpatient coverage with a specific model in mind. CEO #3 urged fellow CEOs to keep their minds open so they will be able to recognize unusual opportunities which might present themselves.

SUMMARY OF INTERVIEW WITH CEO #4

Located within the hospital's service area are two rural health clinics and a Federally Qualified Health Center. About two years ago, the primary care physicians on the medical staff began to object to accepting patients for hospital care who were not their regular patients. In some cases, these patients were coming from the clinics and in others, these patients simply had no local doctor.

To alleviate the problem, the hospital agreed to pay two primary care physicians already on the medical staff the sum of $500/week to assume responsibility for these unassigned patients. In addition to this, these physicians are paid professional fees equal to the Medicare fee schedule, regardless of the patient's payer. On the average week, about six patients are admitted to the hospital to the care of the "hospitalist".

The hospital has no full-time specialists, but operates several specialty clinics. These specialists only rarely do surgery which would require a post-op inpatient follow-up.

The hospital says it is losing money on the provision of this care because it pays both a stipend and a rate above what it is reimbursed (i.e., the Medicare rate), but it feels this is its only hope to provide care for these patients and keep its physicians satisfied.

The hospitalist on call sees those patients who are unassigned. When asked to gauge the community satisfaction, the CEO reported there have been no problems because the alternative for these patients is to have no physician at all. Patients have not voiced unhappiness with this arrangement.

The ED physicians reportedly work well with the hospitalists. The hospital recently switched from an ER group composed of physicians with whom the hospital directly contracted to an ED physician group. A change was made in order to provide reliable

coverage of the rotation, get advice for better reimbursement rates, and to start to build data for quality and finance. The physicians who work for the new ED group are virtually the same physicians who had direct contracts with the hospital.

The CEO's parting comment was that the system works for the moment, but it is fragile. It works only as long as the two "hospitalists" continue to accept the arrangement.

SUMMARY OF INTERVIEW WITH CEO #5

Hospital #5 is located in a community where the two primary care physicians generally do not admit patients to the hospital. The hospital has a contract with an Iowa-based physician group which provides coverage twenty-four hours per day by a physician who will staff the ED, serve as hospitalist, and staff the hospital's adjoining clinic.

The CEO reports the hospital has an average daily census of 1-2 in acute and another 7-8 in swing beds. The hospitalist also covers the ED seeing an average of 4-5 visits per day. The clinic sees about seventeen thousand visits per year (46.6/day). The CEO later commented the physician is seeing 60-70 patients a day in the clinic, and the time is approaching when the recruitment of another physician to work in the clinic is likely.

The doctors employed by the group seem to like working at Hospital #5. Generally, care is provided by three physicians who rotate providing the coverage. Almost all of the patient contact occurs during "normal" hours of the day. The pace is such that they are busy, but manageable. The doctors seem to appreciate being able to see a good mix of patients with differing problems. All three are from the Chicagoland area. This arrangement was in place when the current CEO arrived four years ago.

One of the physicians in the rotation works three days per week, equivalent to an FTE. The group is paid slightly more than $100 per hour, but that is the total cost of the program including malpractice insurance, management fees, profit, etc.

The hospital is managed by a hospital system. Hospital #5 is beginning to see specialists on a part-time basis coming from another nearby larger hospital, part of the same system.

Advice provided by the CEO includes that the size of the hospital and patient volumes are critical. The smallness of the volume dictates using this model simply because there is no other choice. This arrangement will allow the hospital to recruit more primary care physicians in the future. Without hospitalist coverage, physician recruitment would likely be nearly impossible.

The key to the success of this program is the consistent set of doctors who rotate to the community. If the pool was larger, then variability would occur which would be very bad for both the hospital and for the patients.

SUMMARY OF INTERVIEW WITH HOSPITALIST AT HOSPITAL #6

Hospital #6 is a CAH owned by regional system. The hospitalist interviewed has not only hospitalist responsibilities, but significant management as well. The hospital also has a round the clock ED and a federally-designated rural health center staffed by seven physicians and three physician assistants. The Clinic is open sixteen hours per day, seven days per week and saw 37,000 patient visits in the last year.

The ED is active with 3,600 visits last year. On weekdays, the ED is staffed by the hospitalist who works 8:30 to 4:30, Monday through Friday. The "Doctor of the Day" in the Clinic then staffs the ED for the remainder of the day.

Around fifteen years ago, the hospital found itself in a situation where almost all of the local health care providers were employed by competing hospitals. Consequently, the future of the hospital was bleak. The newly installed administration responded with the creation of a primary care clinic. That clinic today is responsible for all but a hand-full of patient admissions.

Because the idea of a full-time hospitalist has evolved, it is difficult to obtain hard data as to the impact of the hospitalist to admissions or patient satisfaction because there is no "clean" "before" data. However, the hospitalist believes that having a hospitalist has made a very positive impact on the admission rate of the hospital. The CEO also believes that without hospitalists, the CEO could not have obtained the last two recruited physicians.

When asked about quality, no specific data is available. The hospitalist pointed out that even as the hospitalist only works weekdays, there is a good understanding that the hospitalist is responsible for assuming management of the care of each patient in the hospital. Having one source for this care management direction has improved communication among other physicians and hospital staff. The hospitalist believes this element alone is responsible for improving patient care for inpatients.

The hospitalist reports that in major medical centers, hospitalists are expected to assume care for twenty to thirty patients at all times. The hospitalist believes it is not difficult for a hospitalist in a rural setting to assume care for a minimum of twenty patients. With the average CAH having far fewer patients, it stands to reason that a hospitalist who only cares for inpatients in a CAH is going to be underused and bored. The hospitalist said responsibilities as a hospitalist coupled by daily responsibility to cover the ED is a comfortable level.

The hospitalist and all other providers associated with the program are employed by the hospital. When asked about using physician contracting firms, the hospitalist said this was doable as long as the firm recognized the need for the contract physicians being busy and willing for the physicians to assume responsibility for patients in both the ED and inpatient setting. The hospitalist said that many firms strictly provide physicians to EDs, but many are now willing to accept a broader scope of responsibility.

When asked about the relationship between the hospitalist and specialists, the hospitalist replied that few specialists live in the community, but they travel to the community to see patients in clinics established by the hospital. In most cases, these specialists are employees of the hospital system. Only rarely do they perform surgery which requires that the patient is admitted, requiring next day follow-up. Therefore, only rarely is it necessary for a specialist to "hand-off" a patient to the hospitalist. In most cases, the patient is admitted and followed by the hospitalist with support from the specialist. The hospitalist will quickly point out that the only way the hospitalist program could be financially justified is to combine responsibilities with the ED.

When asked about financing hospitalists, this hospitalist confirmed published information saying that annual compensation for a hospitalist in a CAH should be around $200,000. Further, from a revenue standpoint, it is critical for the hospitalist to fully understand how reimbursement and billing for the provider fees really works. The hospitalist said that for many patients the hospitalist sees in the ED then subsequently admits, the hospitalist waits until the day after the admission to do the history and physical because reimbursement is improved. There are a myriad of things a well trained hospitalist can do to enhance reimbursement with an eye toward generating the revenue necessary to recoup as much of the program cost as possible.

In the past four years, clinic visits, inpatient admissions, and ED visits have each increased around ten per cent annually.

When asked for advice to CAH CEOs, the hospitalist replied that one must look seriously at the hospital's transfers to understand what kinds of patients are "going out the door". Most CAHs have an ability to care for many more patients than are admitted to their facilities. The CEO needs to review transfer data to determine which patients are being transferred because the local physician is unwilling to assume inpatient care for the patient.

The second thing to look at is patient origin studies for competing hospitals. "How many patients from the hospital's service area are leaving the area for primary care because they are unsure of what would happen to them if they needed hospitalization?".

A savvy hospitalist who is in touch with the community and the medical staff ought to be able to reverse both of the above described trends.

Last, CEOs need to look toward the future of healthcare quality. Reduction of variations must be a goal. There needs to be a doctor in control of the admission and there needs to be a way for that physician to come under the control of the hospital, i.e., alignment of incentives, interests, and goals for the patient.

SUMMARY OF INTERVIEW WITH CEO #7

The hospitalist program at Hospital #7 began two years ago when the hospital was in the process of changing its emergency department physician group. The decision to change the ED physician group was stimulated by a desire on the part of the hospital to improve ED services and to improve the image of the hospital's ED services in the community. When the decision was made to secure the services of a new group, the hospital also decided to ask groups offering proposals to include hospitalist services as a component of ED coverage.

CEO #7 reported that the ED saw 8,000 visits last year, and the inpatient average daily census is fifteen.

The CEO said after interviewing several ED physician groups, a Georgia-based group was selected. The CEO reported that at about the same time they were looking to replace their ED group, several primary care physicians in a nearby regional center were leaving that location. CEO #6 had conversations with them as they were interested in contracting directly with the hospital to provide ED services. The CEO prevailed upon these physicians to be employed by the new physician contract group and then be assigned to Hospital #7. In the end, the two main ED physicians/hospitalists came the hospital as a result of that situation. The CEO said this was especially helpful because they knew and understood the region before they came to the community.

The ED/hospitalist contracts with a physician group which bills for ED services and retains professional services fees as well as the hospital paying the group an additional stipend. Therefore, if hospitalists assume more hospitalist care, the Group will receive additional fees for taking care of inpatients, but does not have additional costs. On the other hand, there is no additional direct cost to the hospital except that its paid physicians no longer receive professional fees for taking care of inpatients. Globally, this becomes an advantage to the hospital only if it can increase its patient volumes in the clinics, the ED, or as inpatients.

The ED group schedules one physician on duty at the hospital in twenty-four hour shifts. For the first year, the group physicians provided only ED services. However, as local primary care physicians began to phase out their inpatient care, the ED/hospitalists began to pick up more and more patients. Currently, there are eight primary care physicians in the area. All of these are employees of the hospital and are on contracts which incentivize for increased productivity. If these physicians sign their inpatients out to the hospitalist, their income will be reduced unless they off-set this with more patients. So far, two of the eight physicians sign out all of their hospitalized patients to the hospitalists. However, as time goes on, more and more sign-outs to the hospitalists have occurred from the other primary care physicians.

When asked about public reaction to hospitalists, CEO #7 said the hospital prepared a brochure that was distributed to the offices of physicians who signed out to the hospitalists. The brochure described what hospitalists did and how they would take care

of the patient while the patient was hospitalized. Further, the CEO said that the primary care physicians did a good job of explaining hospitalists to the patients. Last, CEO #7 said that since all of the physicians work for the hospital and because they have all shared call for several years among themselves, most patients were already accustomed to the fact that they might see a different physician as a part of their care.

The CEO pointed out that prior to the advent of the new ED/hospitalist group, there was often difficulty in getting patients transferred from Hospital #7 to tertiary care centers in St. Louis or on the East Side. The CEO said with the new ED group, these problems have been eliminated. The physicians in the Hospital #7's ED now know the best way to get patients transferred, and this has noticeably reduced the waiting time for patient transfers. The transfer process has been streamlined.

The CEO said that with the retirement of a local primary care physician, the hospital is now attempting to recruit a family practitioner. The CEO said that right now, physician recruitment is far more difficult than the CEO has ever seen. The CEO thought it would be nearly impossible to recruit a family practitioner to a rural area if there was still traditional call rotations for acute patients. The CEO thinks having a good ED and hospitalist program will provide a recruiting advantage. Even with a physician in-house twenty-four hours per day, it is still necessary for the primary care physicians to rotate "on-call" as a back-up to the ED/hospitalist and to take care of newborns. The ED/hospitalists have no responsibilities for OBs or newborns at the present time (this is the choice of the current medical staff).

One of CEO #7's challenges today is to convince the primary care physicians that if they give up their hospital care to the hospitalist, they need to add hours to their clinic time to off-set the loss of income. The CEO said they are gradually coming to the realization that this is workable. The CEO pointed out this is an obvious financial benefit to the hospital. The CEO said the hospitalist program really does not increase expense to the hospital because these physicians are already paid to be at the hospital to cover the ED. When the volume of patients in the ED is low, then they ought to be able to assume care of hospitalized inpatients. In the end, the financial incentives for the hospital appear to be in order.

When asked about quality, the CEO said the hospital has no empirical data, but that it makes sense that quality would be improved with the introduction of hospitalist services. CEO #7 said patients benefit by having someone right there at all times to order then react to lab and x-ray results. Because of this, the average length of stay for hospitalist patients is lower than the rest, but patient satisfaction seems higher because patients have near immediate access to the hospitalist rather than having the family waiting around at certain times of the day to "catch" the primary physician when he or she does rounds, a great frustration of patients.

When asked for advice to share with peers, this CEO replied that it is important to let the physicians make the decisions related to call. "You can create a really good hospitalist

program, but you can't force it on them". CEO #7 urged fellow CEOs to not overly pressure the situation attempting to force change contrary to the existing physicians.

SUMMARY OF INTERVIEW WITH CEO #8

The CEO of Hospital #8 clearly has an accounting background, yet contends the primary consideration of a hospitalist program should not be "dollars and cents".

Prior to February, 2007, Hospital #8 had an ED group that was receiving only mediocre satisfaction scores from patients and medical staff. New young physicians recruited to the community insisted that hospitalist services be initiated. When the hospital was unable to find an ED group willing to also provide hospitalist services, they worked with a physician who provided ED coverage to assist this physician to establish a new group.

The new group contracts with six to eight physicians who are all board certified in emergency medicine, internal medicine, or family practice. The physicians cover both the ED and hospitalist roles for twenty-four hours shifts, twenty-four hours per day.

The contract with the group provides that it will receive a bonus of high patient and medical staff satisfaction scores. Further, it provides that time allocations will show that seventy per cent of the hours will be spent in the ED and thirty per cent performing hospitalist responsibilities.

With one exception, members of the medical staff were unwilling to routinely care for inpatients, both acute and swing bed. The group now takes care of the ED and inpatients including acute, swing bed, and observation.

Statistics as follows:

ED Visits (annual):	5,500
Acute (ADC):	7 (this includes OB)
Swing ADC:	3
Observation:	3

The group's physicians do not take care of OB patients or newborns and shy away from pediatric patients because most are internists.

If the ED/hospitalist is overwhelmed, he/she will call the group and request additional support. One of the members of the group lives in town and immediately responds for whatever time is necessary. The hospital agrees to pay extra for these additional hours.

When asked about stress placed on ancillary departments with the introduction of a hospitalist, the CEO responded that they already had an active twenty-four hour ED, so there was little change.

When asked about the response from the community to the hospitalist program, he said the last remaining problem with this arrangement to be solved is that patients sometimes complain that they are seen by a different doctor everyday as each ED/hospitalist works a

24 hour shift. However, the CEO points out that patient satisfaction scores have consistently been above ninety-five per cent, reaching one hundred per cent last month. He said the existing medical staff does a good job of explaining to patients that they will not see the patient in the hospital and that the hospitalist with take charge of the patient's care. Last, each physician's office is provided with pamphlets about the use of hospitalists.

He said the Group makes very heavy and consistent use of treatment protocols or clinical pathways. They are now incorporating CPOE which will make the ranges of treatment even more consistent.

The average age of the medical staff is forty-two, a very young medical staff.

The use of hospitalists is not mandatory. There is one primary care physician who rarely uses the hospitalist, but he is the only one. Sometimes primary care physicians have special patients who they round on in the hospital.

The CEO provided details on costs and reimbursement as a result of the hospitalist program.

In the first year of the program, they experienced an increase in inpatient volumes of twenty per cent. He said the decrease in transfers from the ED was significant. The inpatient mix at this hospital; is 75% Medicare, 20% commercial, and 5% Medicaid or self-pay. Before the hospitalist program was begun, 38% of inpatient admissions came from the ED. Now that number has jumped to 60%. The average length of stay has dropped to 3.2 days.

"Because we have a hospitalist, we may have averted a couple of primary care docs from taking an early retirement".

"There is no way we could or would ever want to go back. The place would just implode on itself."

Advice to other CEOs: "Quit worrying about dollars and cents but look at the big picture of patient and medical staff satisfaction". Medical staff/hospital collaboration has never been better. "If you have a good handle on the revenue cycle, then there will be money there to make it work". "Controlling the revenue cycle" is critical.

SUMMARY OF INTERVIEW WITH CEO #9

CEO #9 opened by emphasizing that what is discussed in the interview is purely a plan. He said Hospital #9 is owned by a regional healthcare system which also owns a nearby regional medical center which provides tertiary care. He said the regional center frequently reaches its capacity while Hospital #9 generally has beds available.

The regional center has a successful hospitalist program with the physicians being under contract with the regional center.

The objective of the plan would be for Hospital #9 to increase the number of patients who generate revenues for the system and to help alleviate the resource strain on the regional center. To accomplish this, they are exploring the possibility of the regional center hiring an additional hospitalist on the day shift, who would spend part of his or her day at the regional center while also traveling to Hospital #9 twice each day to see inpatients. Hospitalists at the regional center would also be available at nights for consultation via telephone to the hospital staff. An attempt will be made to convince regional center doctors who currently admit their patients to the care of hospitalists at the regional center to allow these patients to be admitted to Hospital #9.

CEO #9 said they investigated the possibility of asking their ED physicians to also assume the roles of hospitalists at Hospital #9, but the workload in the ED precluded this at least on a consistent basis.

CEO #9 said he would keep ICAHN posted as to their progress. The CEO admitted this situation is unique in the following ways:

(1) Both the primary and tertiary hospitals are geographically close enough to share hospitalist services.

(2) Both hospitals are in the same system.

(3) The tertiary hospital frequently reaches capacity while the CAH generally has some empty beds.

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B. Hospitalist Physician Group Evaluation/Decision Matrix

One Illinois CAH conducted an investigation into the possibility of creating a hospitalist program in late 2008. Because of the specific situation at this hospital, the "list of possibilities" was limited to an evaluation of four contract hospitalist physician groups. The Chief Executive Officer was kind enough to provide to the author a matrix used by the hospital to display the evaluation of each of these contract firms.

An Excel spreadsheet was used with the names of each of the contract firms along the top as column headings. Along the side (rows), the following criteria were listed and evaluated within the matrix:

Company Info (type of ownership, i.e,. private, nfp, etc.; location of home office, when business was founded)

Contacts (name, address, and e-mail of contact for firm)

Hospitalist Programs; Small/Rural Programs (number of contracts in each category provided by the firm)

Physician Description (specialties/mix by per cent; board certifications required

Physician Training (description of training programs in hospitalist medicine required of hospitalists by each firm)

Retention Rate (turnover of physician personnel – expressed as percentage)

Program Structure Proposed (number of physicians, hours of shifts, on-call coverage, response rates, etc.)

Support Staff (describe the firm's support staff)

M.D. Communication (describes when and how the hospitalists will communicate with other physicians, i.e., "admission, sentinel events, discharge fax, discharge summary, use preference cards for physicians")

Hospital Communication (formal structures such as Joint Operations Committee, hospital report card, etc.)

Changes to Expect (examples: "50% growth in 90 days", "Standards of Care", "New documentation tools"

Time to Start Program (start-up time)

Professional Billing (Who will do the billing of the professional component?)

Proposed Pricing Structure

References (each firm provided CAH references where the firm supplies hospitalists to these facilities

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XI. Author Biography

William Spitler earned a B.S. from Eastern Illinois University, a M.A. in Public Administration from Sangamon State University (now University of Illinois – Springfield). He has completed additional studies at the University of Minnesota, Executive Development Program. A Fellow in the American College of Healthcare Executives, he was the Associate Administrator and then President of Perry Memorial Hospital in Princeton, Illinois from 1976 until 1999 when he retired. In "retirement" he has worked part-time as a hospital management consultant for Illinois critical access hospitals and served as the Special Projects Consultant for the Illinois Critical Access Hospital Network.