Hospitalists Get High Marks

Satisfaction *from page 1*

venience, and responding quickly to a nurse's concerns.

Patients who are unfamiliar with the hospitalist model may become dissatisfied if the hospitalist has little knowledge of the patient's history, if the referring physician does not inform the patient about the hospitalist's role, or if the hospitalist does not explain his or her relationship with the referring physician, Dr. Whitcomb said.

See related commentary on page 14.

Satisfaction scores are most visible on the Web site of the Centers for Medicare and Medicaid Services, at www.hospitalcompare.hhs.gov. The scores are taken from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which has three physician-specific questions (the possible responses are never, sometimes, usually, or always):

► During this hospital stay, how often did doctors treat you with respect?

► During this hospital stay, how often did doctors explain things in a way you could understand?

► During this hospital stay, how often did doctors listen carefully to you?

Dr. Whitcomb urged hospitalists to familiarize themselves with those questions as a way to boost patient satisfaction results. "My hospitalists really took this to heart" after learning about the survey questions, he said.

In an effort to improve hospitalist performance, Dr. Whitcomb developed a patient satisfaction survey instrument in collaboration with Nancy Mihevc, Ph.D., a consultant in Florence, Mass. They have used it to query patients at three hospitals: two urban hospitals with relatively mature hospitalist programs, and one suburban hospital with an "adolescent" program, he said.

"I was surprised at how happy patients were with their hospitalist," said Dr. Whitcomb, adding that he expected them to say that they preferred their personal physician over the hospitalist.

Patients were most satisfied when hospitalists spent time with them, seemed to be easy to talk to and available, and provided good coordination of care. High marks also were given when the physician managed transitions well and treated pain. And most patients wanted a business card, and said that getting one was memorable, he said.

Dr. Mihevc said that surveys should be designed based on the main objective, such as getting an outside perspective on quality, focusing on a previously identified problem area, assessing whether an improvement project is effective, or providing data to credentialing or payer organizations.

As for benchmarking, Dr. Whitcomb said that he did not think that hospitalists should be assessed in comparison with all other physicians. Instead, they should be benchmarked against other hospitalist groups at comparable hospitals, but that can be difficult. One alternative is to compare hospitalist patients admitted through the emergency department to all medical patients admitted through the ED. Patients who are admitted through the ED tend to be less satisfied overall, so their ratings can provide a kind of baseline.

Hospitalists can improve patient satisfaction by having a script for each encounter, handing out business cards, or offering brochures with a picture of the physician, answers to frequently asked questions, and contact information for the hospitalist. Hospitalists also should respect patient privacy and specifically name the receiving hospitalist when handing a patient off in the middle of a hospital stay, Dr. Whitcomb said.

Another good technique is to conclude a visit by sitting down with the patient and asking an open-ended question, thereby encouraging the patient's involvement, he added. ■

Disclosures: *Dr. Whitcomb reported that he receives research grants from the SHM.*

Family Opinions Important in Recruiting Hospital Faculty

When recruiting top personnel to a hospital, it's crucial to gain the approval of the candidate's spouse and family, according to an online survey conducted by the executive search and consulting firm MillicanSolutions.

The survey, which included responses from 36 academic medical centers in the United States and Canada, showed that although work environment and salary were the top challenges in retaining faculty members, the concerns of family members and spouses were the most important elements in the recruiting process. The survey was conducted in collaboration with the Association of Administrators in Academic Pediatrics.

More than a third of the respondents ranked family and spouse concerns as the greatest challenge in recruiting faculty. About 21% cited salary and benefits, and only 10% of academic medical centers said that work environment was a major factor. Similarly, family and spouse concerns were the top reasons cited by candidates in rejecting a job offer. Family matters also topped the reasons for resignation in the survey.

Hospital executives should pay attention to this trend and bring families into the interview process early, said Wesley D. Millican, CEO of MillicanSolutions. Typically, spouses and family members don't visit the facility until the second interview. Hospitals can save time and money by involving families right away and finding out what they want, which may have more to do with sports and music opportunities for children than with salary and advancement opportunities, Mr. Millican said.

—Mary Ellen Schneider

Managing Patient Assignments Properly Boosts Efficiency

BY ALICIA AULT

FROM THE ANNUAL MEETING OF THE SOCIETY OF HOSPITAL MEDICINE

NATIONAL HARBOR, MD. — Hospitalists within a practice most likely know which of their colleagues want time off on nights and weekends, but they probably haven't given a lot of thought to how to efficiently assign new patients, Dr. John Nelson said.

Managing patient assignments successfully improves physician and patient satisfaction, said Dr. Nelson of Nelson Flores Hospital Medicine Consultants, La Quinta, Calif., and Dr. Troy W. Ahlstrom, chief financial officer of Hospitalists of Northern Michigan, Traverse City.

A successful assignment system feels fair to the hospitalist, supports continuity of care, and allows other physicians in the hospital to always know which hospitalist is caring for a patient, said Dr. Nelson, who also is the medical director for the hospitalist practice at Overlake Hospital, Bellevue, Wash.

One commonly used method involves distributing patients sequentially and assigning based on location—for instance, one physician takes floors 1 and 3, and another floors 2 and 4. Load leveling also is common, but can be time consuming to manage, Dr. Nelson said. With that method, the next patient is assigned to the physician with the lightest patient load at that time.

Less common is uneven assignment, when one physician might take all the admissions on one day and none the next. Another method is for a hospitalist to be paired with a primary care physician, taking all of his or her patients. With this approach, the primary care physician will always know who is covering his or her patients, and patients who are admitted repeatedly will always have the same hospitalist. A variation is for repeat patients to always be admitted by the same physician.

Even with an assignment scheme in place, hospitalists have to be prepared to cope with special cases, such as "bounce backs"—patients readmitted shortly after discharge. Dr. Nelson suggested establishing a formal policy on how to handle such situations. Formal policies should also be in place for assignment exceptions when one hospitalist is at the cap for new admissions and the others in the practice are not, or when other physicians request a consultation with a specific hospitalist. Finally, practices should anticipate what to do when a patient "fires" a particular hospitalist, and they should have a policy for that, he said.

Using a "triage" or "hot" pager, in which all patients are routed first through the pager operator, usually a hospitalist, can also help with assignments, Dr. Nelson said.

Another option is exempting hospitalists from taking any new admissions the day before they rotate off shift. Assuming that the average length of stay is 4 days and that hospitalists work 7 consecutive days, this method of assignment means that 71% of patients will see the same physician throughout their stay, Dr. Nelson said. If, instead, the physician gets the same patient load every day, including the day before going off shift, only 57% of patients will see the same hospitalist for the duration of their stay.

The advantages of the exemption scheme include better continuity of care, fewer handoffs, and more time for the physician to "tee up" patients for the incoming hospitalist, Dr. Nelson said. However, it also means that the other physicians in the practice will need to take more patients on some days.

Dr. Ahlstrom said the traditional model of 7 days on/7 days off did not work well at his practice at the Alpena (Mich.) Regional Medical Center. So the Alpena practice instituted a flexible full-time equivalent (FTE)–based work schedule that allows each hospitalist to tailor his or her patient load each day.

It's a somewhat complicated approach, however. The FTE is defined by the number of patients seen per day—for instance, if the FTE is defined as 16 patients a day, and the practice admits about 160 patients daily, 10 FTE physicians are needed to cover each day. Physicians are queried about how many patients they want to take on each day. They are assigned FTE numbers based on patient load and then scheduled accordingly so that the entire practice has coverage for all of the anticipated admissions.

The flexible schedule lets the physician work in a pattern that is optimal for his or her lifestyle and compensation needs, Dr. Ahlstrom said. Finally, although it's a great retention tool because it allows physicians to maintain a work-life balance, it can make recruitment more difficult because there can be some initial resistance to nontraditional scheduling, he added.

Compensation is based solely on productivity, which may give some hospitalists pause. Because it is so complicated, the Alpena practice has a dedicated employee who works 20-40 hours a week solely on scheduling at the three hospitals it serves. Start-up costs are about $20,000, primarily for the software and hardware needed, he said. ■

Disclosures: *Dr. Ahlstrom disclosed that he is a consultant with Hospital Solutions of Michigan. Dr. Nelson reported that in addition to his consultancy, he is a stockholder in Ingenious Med.*