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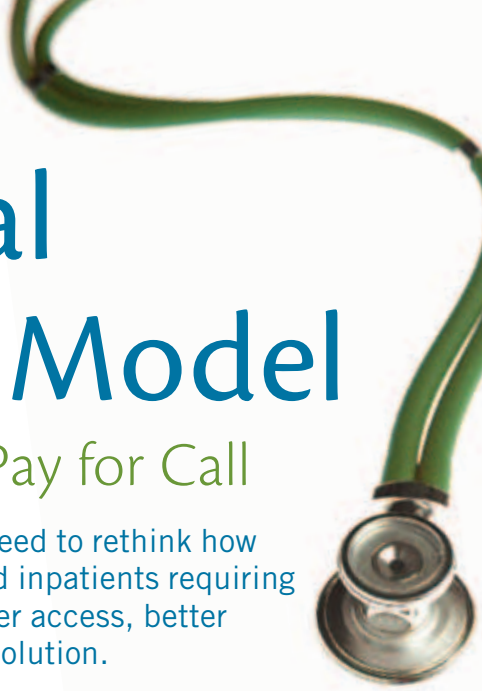
The Surgical Hospitalist Model

A Better Alternative to Pay for Call



As the number of general surgeons continues to decline, hospitals need to rethink how surgical care is provided to emergency department (ED) patients and inpatients requiring surgical consults. The best solutions will achieve the trifecta of better access, better quality, and lower costs. A surgical hospitalist program is one such solution.

By definition, a surgical hospitalist is a physician trained in general surgery who is dedicated to caring for hospital patients, including ED, observation, inpatient, and postoperative clinic care. The role of the surgical hospitalist is to improve patient throughput, alleviate ED backlogs, eliminate the need for community-based physicians to participate in on-call schedules, and address important quality and performance goals.

More hospitals are finding that by developing a surgical hospitalist program, they can not only secure surgical coverage but also enable surgeons to more efficiently balance call demands with elective business and improve hospital and surgeon alignment around key goals. Kaweah Delta Medical Center (KDMC) in Visalia, CA, is one example.

Creating a Surgical Hospitalist Program

Like many hospitals, KDMC was faced with a very difficult situation: a declining base of general surgeons and a reluctance of the remaining surgeons to take call. Even after offering generous call coverage stipends, the hospital was confronted with disgruntled surgeons who expressed their intent to leave the medical staff and practice ambulatory surgery.

Hospital and medical staff leadership knew they had to rethink how surgical coverage was provided at KDMC. After agreeing on several guiding principles (including securing patient access, enhancing the quality of care, reducing the cost of care, and improving physician retention and recruitment) and engaging in a joint planning process, hospital leadership and select surgeons elected to develop a dedicated surgical hospitalist program.

As a first step, a goals grid was created based on broad input from surgeons, medical staff leaders, and hospital executives (figure 1). The goals defined the preferred long-term direction of the new program and helped focus planning efforts.

KDMC then moved forward with the following four steps to build the program.

1 Form an organized surgical physician group.

A major factor driving success was the early decision to form an organized surgical group—something that had been missing from KDMC's medical staff, which was composed of mostly solo practicing surgeons. The new surgical group was formed by a select group of surgeons with practices located in the community, who initiated plans to structure the new group as negotiations with the hospital commenced.

The surgical group was formed as Friendly Professional Corporation, with a single physician serving as the sole owner. This allowed other surgeons the flexibility to contract with the new group on a part-time basis. With the group formed, physicians were able to consolidate operations and align to improve quality, reduce costs, and ensure appropriate coverage.

2 Ensure coverage by calculating full-time equivalents (FTEs) and establishing a staffing model.

Extensive review of hospital and physician data was conducted to determine how many physicians would be needed to staff the program. Factors impacting the demand for general surgery coverage included emergency and trauma surgical cases, ED and inpatient consults, and postoperative care. The analysis estimated that the average daily workload would include approximately 24 encounters, such as ED and inpatient consults, and approximately six surgical cases and other procedures.

Based on the estimated daily workload and staffing model assumptions, KDMC calculated a need for five general surgeon FTEs to provide the necessary coverage. Similar to other coverage-based specialty programs, the surgical hospitalist staffing model specified four different call positions. Under this schedule, each surgeon takes a first-call, second-call, post-call, and clinic shift each week.

3 Define the physician compensation model.

KDMC recognized that compensation had to be competitive in order to retain and recruit surgeons for the program. Additionally, incentives had to align surgeons with hospital quality and service initiatives. Because of KDMC's high percentage of uninsured and underinsured patients, the hospital assumed any shortfall in professional revenues less market-level expenses, including physician compensation and benefits. The compensation model developed provides surgeons a base salary plus incentives for high quality and service. Surgeons can earn even more if productivity surpasses a predetermined threshold.

The financial arrangement sets funding at the group level, which allows the group the autonomy to determine distribution at the individual surgeon level. This model also enables the group to easily add or remove surgeons from the program and reduces the need for the hospital to monitor physician FTE requirements. By placing a floor on funding levels, the group is able to limit downside risk and more easily recruit and retain physicians.

4 Structure the outpatient clinic.

The program offers patients access to outpatient care four half-days a week. Access to follow-up care is offered at a designated physician practice, with the intention to transition care to a hospital-based clinic in the future. Each surgeon rotates through the clinic, and steps are taken to help maintain continuity of care for patients.

An Effective Model for Alignment and More

For KDMC, the surgical hospitalist model is proving to be an effective way to align with general surgeons to provide timely and high-quality emergency surgical care. The organization has also realized an approximate 25 percent increase in surgical cases, because private practice surgeons are able to focus more on their specialties without the disruption of emergency call. Patient rounding has become more consistent, and discharge planning is more timely. Consequently, the length of hospital stays for the five most common types of surgical patients has been reduced by 1.5 days. Development of standardized orders and set surgical pathways has also led to reduced costs of care and enhanced quality.

Given the demonstrated benefits, the question is not if the surgical hospitalist model will become the norm, rather how quickly general surgery will transition to this model. ❍

Figure 1

KDMC's Surgical Hospitalist Program Goals Grid

	HAVE	DO NOT HAVE
WANT	**Preserve** ◆ Retention of physicians ◆ Private practice physician incentives ◆ Current referral relationships ◆ Excellent clinical quality ◆ Physicians' commitment to KDMC ◆ Strong physician leadership	**Achieve** ◆ A highly collegial group culture ◆ Support from other specialists ◆ Tightened hospital/physician alignment ◆ Complete specialty coverage ◆ 100% call coverage ◆ Level 3 trauma designation ◆ Increased number of elective cases ◆ Establishment of order sets and protocols to reduce variation and improve quality
DO NOT WANT	**Eliminate** ◆ Medical staff distrust of physician organization/ hospital administration ◆ Problems with physician accessibility ◆ Patient "dumping" from other providers ◆ Unrealistic expectations on the scope of practice for the surgical hospitalist ◆ Operational challenges with perioperative services	**Avoid** ◆ Out-migration of elective surgical patients ◆ Loss of physician clinical authority ◆ Clashes with other specialists ◆ Poor coding and revenue cycle management of surgical practices

Source: ECG Management Consultants, Inc.