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IT'S NOT NEWS to Ricardo Nario, MD, director of the hospitalist program at Massachusetts' Cape Cod Hospital, that filling vacant positions can be tough. That's because his group is one of many in the East that operate with unfilled positions. Three years ago, the 28-provider program needed to hire five FTE hospitalists; they are still short three. Meanwhile, moonlighters cover many of the program's night, weekend and daytime admitting shifts.

What is a bit shocking, however, is the conclusion that he and his administration and recruiters have reached after talking it over for the past year: They plan to remain slightly short-staffed. That's not to save money or out of desperation, but because it may allow them to do a better job.

"We have this beautiful per diem pool that we have worked hard to build, and we will lose them if we don't use them enough," Dr. Nario explains. While the group wants to fill two vacancies, "we will probably keep one FTE unfilled purposely for that."

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~ Ricardo Nario, MD
Cape Cod Hospital

With that staffing strategy—using mostly employed providers, some contract workers and an occasional back-up locum—Dr. Nario expects to cover all shifts while not burning out anybody or breaking the bank. Just as important, the arrangement will allow him to flex staffing up or down to accommodate dramatically different winter and summer patient volumes.

"If we say to the per diems that they can work only July and August, they'll find jobs elsewhere," Dr. Nario says. "We need access to this pool for July 4 through Labor Day."

And if the per diems were to drift away, Dr. Nario fears he would be back to the hospital's old way of doing things: depending on locums and begging staff to work extra shifts. With locums, he says, "the costs are astronomical," and internal moonlighting is insufficient. "People come here for the lifestyle. We have a very stable program with little turnover, and we don't want to hurt that." The per diem pool consists of about 25

vetted, credentialed and trained hospitalists, with a core group of six who work regularly. Most travel 1-1/2 hours from Boston for their Cape Cod shifts.

Dr. Nario's decision to keep some positions permanently unfilled may not be unusual. Conventional wisdom—along with many hospitalist leaders and consultants—holds that a program should be fully staffed so committed hospitalists have the time and energy to provide consistently high-quality care. Plus, employees are usually considered to be more invested in their jobs than contract workers and more attuned to their health system's priorities.

But, like Dr. Nario, some hospitalist directors are finding that making due with less is less of a hardship than they imagined. Then there's the fact that necessity can be the mother of invention: Working short-staffed may mean coming up with ways (or reworking schedules) to be more efficient. That way, hospitalists can comfortably see a few more patients per day—or groups can figure out different ways to cover shifts.

Empty slots

According to the Society of Hospital Medicine's 2018 State of Hospital Medicine Report, two-thirds of adult hospital medicine groups report having unfilled positions. Their median percentage of staffing that remained unfilled during the year was 12%. In other words, a 25-provider group likely has three empty slots.

"I don't know that I would completely fill us with employees if I could, given how flexible this resource has been."

~ David Lovinger, MD
NorthShore University HealthSystem

The vacancy situation is worse in the East, where 79% of programs report having unfilled positions. It's only slightly better in the West, with 73% reporting unfilled slots. Groups owned by hospital and health systems and by universities or medical schools are the least likely to report being fully staffed. But according to the survey, multistate hospitalist management companies have the highest "percentage of staffing that remained unfilled during the year," averaging 20%. Cape Cod Hospital's shortfall is right in line with the East's median reported vacancy rate of 15%.

The SHM survey also asked how hospitalist groups cover open positions. It found that most (70%) depend on their hospitalists to voluntarily pick up extra shifts, followed by using moonlighters and per diem/PRN physicians (57%) and locum physicians (44%). Ten percent say they "require" their doctors to pick up extra shifts. Moreover, about one-third (31%) report sometimes operating with "some uncovered shifts," either because they have no other option or they have built in a cushion—or because they want to.

Hospitalist consultant Martin B. Buser, MPH, says he has encountered groups that have chosen to not fill vacancies because current group members want to make more money, even though that means working more. Some programs also discover when working short-staffed that some positions may be more aspirational or historical than essential.

Mr. Buser, a founding partner of the Del Mar, Calif.-based Hospitalist Management Resources LLC, has seen groups that continue to staff for ICU coverage even after their hospital hires full-time intensivists. Or they work short-staffed and find that if they each pick up an additional patient, they can leave a shift uncovered without affecting patient care.

Multiple staffing strategies

Other groups find cushions in coverage of post-acute care or rehab or orthopedic comanagement service lines that they added during growth periods. At Norwood Hospital in suburban Boston, for instance, hospitalist program director Terry Huynh, MD, MPH, says that in a pinch he might reassign the hospitalist doing medical consults on the hospital's psychiatric unit to help out with admissions in the emergency department. While he has never had to do that, there is no doubt that some shifts are busier and more critical than others.

"For us, the mantra is to be overstaffed."

~ Surinder Yadav, MD

Vituity

Although his 17-person group has several vacancies, Dr. Huynh has been able to cover shifts with in-house moonlighters and with a locum pool provided by his employer Sound Physicians, a national health care practice focused on the episode of care. "They are temporary staff who we know," he says. "I haven't had a situation where we haven't been able to find someone" to cover a shift. Easy access to a large pool of

credentialed and vetted hospitalists is, he adds, a benefit of being part of a large national staffing company.

The policy of the Tacoma, Wash.-based Sound Physicians— and, in some places, its contractual duty—is to fully staff the hospitalist programs it operates in hundreds of hospitals across the country, explains chief medical officer Gregory Johnson, MD, a hospitalist in Houston. That is true even if some teams in some hospitals can't—or opt not to—hire fully.

"That's why we have multiple strategies" for filling positions, Dr. Johnson explains. In addition to hiring full- and part-time doctors and advanced practice providers to fill FTE positions, Sound encourages individual group leaders to develop their own pools of independent contractors who can work as per diem moonlighters. The company also operates a wholly owned subsidiary, Echo Locum Tenens, that program directors use to fill vacancies. It also hires full-time "ambassadors" who travel from site to site, working for extended periods of time to cover new or otherwise empty positions.

Each program's leadership has "control locally" over decisions about which and how much of each of these various staffing tactics to use, plus the ability to offer flexible scheduling and incentive pay. "There are a lot of different ways we can make sure that we are being considerate of people and their time and providing opportunities to ensure that shifts are filled," Dr. Johnson says.

More flexibility?

In Norwood, Dr. Huynh says his hiring goal remains "filling slots with employees," but that may not end up being his reality. In fact, his group is not actively recruiting for a daytime admitting shift because, most of the time, "we are able to fill in with our own staff" who want extra shifts.

"We are satisfied with that model," he says. "As a program, you want to meet the hospital's needs, but also the needs of your doctors, and we have some people who want to moonlight."

In the northern suburbs of Chicago, David Lovinger, MD, hospital medicine division chief at NorthShore University HealthSystem, has also made a decision that it's OK—or

maybe even better—to cover some shifts with non-employees than to fully staff his four hospitals.

The group originally decided six years ago to use contract staff "when we couldn't hire to fill our nights," says Dr. Lovinger. (The per diem hospitalists are employed by staffing company HNI Healthcare, which was initially Martin Healthcare Group.) The per diems now cover about one-third of the total shifts on top of those filled by the program's 65 FTE employees.

Using non-employees continued at first, he says, because administration was slow to "allow us to hire enough people." It also supported the staffing model because costs were about the same. Over time, Dr. Lovinger has come to prefer this staffing model.

"I don't know that I would completely fill us with employees if I could, given how useful and flexible this resource has been," he points out.

Making it work

Such staffing, Dr. Lovinger explains, allows him to turn on a dime when he has to. Right now, for instance, "one of our hospitals is being transformed into an orthopedic hospital, so we are ending up seeing more patients because we weren't seeing the orthopedic patients before," he says. And even though he knows his service line will grow 5% every year, "I don't know if it's going to 7% or 3% or in March or August or November. This is an easier way for us to fill our shifts."

While he could have gone to bat to have more positions filled, "it didn't seem worth it to have that fight. If I need to fight with my administration, I will, but I will fight over something else."

The argument that employees provide better quality care than contract workers, meanwhile, isn't so cut-and-dried. In Cape Cod, Dr. Nario says he hasn't seen any difference in the quality of care the per diem staffers provide, especially because he assigns them to admitting or night shifts where they do very little discharging. He uses his employed physicians as rounders.

In Illinois, Dr. Lovinger also primarily assigns contract hospitalists and moonlighters to night, weekend and occasional admitting shifts. "Our folks do perform better than the

other folks because they are more experienced in the system and are a little more invested, but it's a complicated thing to measure," he notes. The trade-off is worth it because "it definitely makes us more flexible."

In addition, both Drs. Lovinger and Nario point out that it's easier to get rid of a poorly performing contract hospitalist than a bad employee. "It doesn't happen often," Dr. Lovinger says, "but I don't have HR breathing down my neck saying, 'You need to give them another chance. You need to document this for another three months.' "

Potential pain

But not everyone buys the proposition that having chronically unfilled positions is beneficial.

"It's an unwritten policy, but for us, the mantra is to be overstaffed," says Surinder Yadav, MD, senior vice president for hospital medicine, critical care and post-acute care for the Emeryville, Calif.-based Vituity, which staffs and operates about 60 hospitalist programs in 15 states. "The pressure is on us as a contracted entity to make sure we are appropriately staffed and all shifts are covered. To have uncovered shifts—we won't let that happen."

In addition, says Dr. Yadav, "we are very focused on provider wellness. When you want to take a vacation, you can, because we are little overstaffed." Vituity also has a pool of dozens of "reservist" hospitalists, full partners in the group who choose to travel and work stints at sites that need coverage. Many groups also use scribes, he says, which "supports staffing" through increased efficiency. "It helps with recruiting too."

Too often when a program is under-staffed, Dr. Yadav points out, "Physicians say, 'We'll be fine. We'll work extra.' But after two or three months, it very quickly turns to, 'I can't do this anymore. This is not sustainable.' We don't want people to get burned out."

Consultant Mr. Buser also worries that groups accepting chronically unfilled positions may be trading short-term gains for long-term pain.

This "short-term rationale that, 'we are doctors and we can do anything,' can have some very serious consequences," he says. Yes, doctors make more money by pulling

extra shifts. “But then people start to get tired, they spend less time with patients and patient satisfaction scores tend to go down. They start to call in more consultants, and you have increased length of stay because you have to get more sign-offs from the consultants before you can discharge.

“You may also see thinner charting “because physicians don’t have the time, and that has a major impact on the hospital’s overall reimbursement,” says Mr. Buser, “And then you lose another person, have no buffer and have to use locum tenens, and nurses don’t know them and they get unhappy. There can start to be a downward spiral.”

But on the other hand, Mr. Buser says there is no reason why groups can’t decide to do more with less by making real productivity-improving changes in how they operate.

The strategies he’s seen that make a difference are employing scribes, instituting geographic rounding, utilizing ancillary personnel, locums and quality temps, and making greater use of EHR charting templates. Such reforms can lead to a 10% or 20% bump up in efficiency, which in bigger groups may mean less urgency to fill vacancies.

“If you have 20 FTEs in a group,” Mr. Buser points out, “and everybody adds just one additional patient to their day, you can cover an FTE right there.” Just as with the challenges hospitals face with nurse shortages, “hospitalist program leaders are learning to be creative to achieve their required results.”

Deborah Gesensway is a freelance writer who covers U.S. health care from Toronto.