



Leadership in Hospital Medicine: Principles of effectiveness through the 4 M's framework

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Hospitalist programs have varying organizational structures and operations. These differences are primarily due to variability in employment models and input from stakeholders in their healthcare systems or institutions.

The primary stakeholders are:

- Hospital administrators
- Primary care providers and other referring providers
- Patients
- Chiefs of service/departments and other inpatient subspecialists

For leaders in Hospital Medicine, members of the hospitalist groups form another bloc of stakeholders. Addressing the needs and concerns of this constituency requires, among many other tools, a *sacred heart* (as mentioned by Heifetz and Linsky).¹

“The most difficult work of leadership involves learning to experience distress without numbing yourself. The virtue of a sacred heart lies in the courage to maintain your innocence and wonder, your doubt and curiosity, and your compassion and love even through your darkest, most difficult moments.” (Heifetz and Linsky)¹

Given the congruence of major operational goals of hospitalist groups and healthcare systems/institutions, leadership meetings with stakeholders should occur routinely. These may be scheduled or unscheduled. Unscheduled meetings can be classified as *emergent or urgent*. The major issues which come up for discussion in various forms, which I hereby refer to as the 4 M's, are:

1. Migration (of patients)
2. MDs
3. Monetary matters
4. Metrics

There is the need to constantly prepare for these discussions by being mindful that the vision of hospitalist groups evolves, and one should not be stuck in groups' tradition or initial vision. Some opportunities must be explored and nurtured for a rebranding of hospitalist groups to achieve new spheres of influence.

MIGRATION: SHOULD HOSPITALISTS CARE FOR ALL INPATIENTS?

The request to have patients of other inpatient services transitioned to hospitalist services, which is a sign of recognition of our skill set, is a potential bane for all groups. Increasing inpatient acuity and complexity of the inpatient work environment encourages and drives this migration. Leaders preparing to take on these challenging transitions should examine the Blake-Mouton management style grid juxtaposing “Care for Task” and “Concern for People” in making the right decisions.² Competency to assume any new roles is of *utmost importance*, and all the required resources needed should be made available to achieve desired outcomes.

Invariably throughput (length-of-stay) expertise is held up as the imperative for these additional responsibilities. However, one also needs to realize there are other options for leveraging this expertise without assuming sole responsibility for the care of all patients. The use of guidelines to ensure appropriate triaging of patients, co-management models, and timely provision of consultative services allows for more efficient use of available resources. The goal is a win-win solution that promotes service quality, expeditious patient care and ensures efficient use of resources.

MDS: DO WE NEED ALL THESE DOCTORS?

What about replacing some with nurse practitioners (NPs)/physician assistants (PAs)? As the cost of maintaining hospitalist programs continues to increase, leaders will have to find answers these questions. As already mentioned, programs/systems are different. What works work in one domain may not apply to others.

The key factors to consider are:

- *Know your system:* In academic institutions and/or hospitals with high inpatient acuity, there is a limit to how far the skill set of allied health professionals (PAs/NPs) can be leveraged.
- *Know the stakeholders:* The clinical climate (expectations of patients and physicians in other disciplines plays an essential role in making changes to the composition of the hospitalist group. This assumes more importance when in a competitive environment with other hospital medicine providers.
- *Know the skill set:* NPs and PAs have varying skill sets based on training and experience. They should be assigned roles within their domain and help with other hospital medicine initiatives such as follow-up consult services, and post-discharge clinics, to free up physicians to assume additional roles.

MONETARY: WHY ARE OUR MONTHLY CHARGES LOW?

This happens when inpatient volume is relatively low or there is a lack of appropriate billing. Leaders need to own lapses in this domain and take steps to address them. Proactive steps must be taken to ensure appropriate billing for the services hospitalists provide. This applies to both adequate documentation to help capture hospital's billing for inpatient services, and provider billing for daily services. Annual educational sessions and periodic audits are beneficial in keeping these issues on track. Additionally, hospitalist leaders should not forget downstream revenue generated by other hospital services from our clinical diagnoses, and the subsequent interventions in both outpatient and inpatient settings.

METRICS: WHAT METRICS ARE USED TO EVALUATE A GROUP'S PERFORMANCE?

Many metrics have been designed to evaluate and boost operational efficiency. Leaders must devote time to learn the key metrics and apply them accordingly.

Operational efficiency depends on three major factors:

1. Awareness of institutions' operations and limitations
2. Timely application of clinical management decisions

3. Appropriate use of available resources to enhance and expedite patient care.

In the world of diagnosis-related groups (DRGs), leaders need to optimize steps to ensure appropriate inpatient LOS (length of stay) and keep our patients' O: E (Observed LOS: Expected LOS) ratios <1. We should be aiming for O:E ratios <0.9.

LOS: depends on many factors, several of which are beyond the control of hospitalists. Early identification of what we can control and adopting measures to fine-tune these steps are needed to create the buy-in required from other services to help us reduce LOS.

Discharge by Noon: This is a metric that has been reviewed in many discussions. The significant point here is to avoid compromising LOS, even as this metric is highlighted. The focus should be on expediting known discharges, as opposed to holding discharge-ready patients till the next morning to meet the proposed metric. Leaders should be aware of discharge efficiency (ratio of discharges over total daily census) and several other throughput metrics that are in use and adopt the applicable ones.

Patient experience: This is a broad challenge that requires system-wide initiatives to achieve set goals. Approaches should center on effective communication, teamwork, and compassion as well as an understanding of survey metrics and other measurement tools employed by the organization. Ultimately the patient's experience is a composite of many factors and hospitalist groups represent an active participant in this domain of inpatient care.

CONCLUSION

Creating a nurturing and learning environment in hospital medicine groups ensures the diffusion of the knowledge, thereby laying the foundation for the achievement of operational and other set goals. 4 M's discussions invariably result in change. Change affects people's sense of value, disrupts role patterns, and can create conflict between perceived winners and losers. Kotter's model of successive change and compromise management, as in the Blake and Mouton grid, are some of the tools utilized by leaders to optimize outcomes of 4M discussions.³

Conflicts of Interest

The author has no conflicts of interest to disclose.

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