The Academic Hospitalists Movement in the United States: Opportunities and Challenges for Patient Care, Education, and Research

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Portland Oregon
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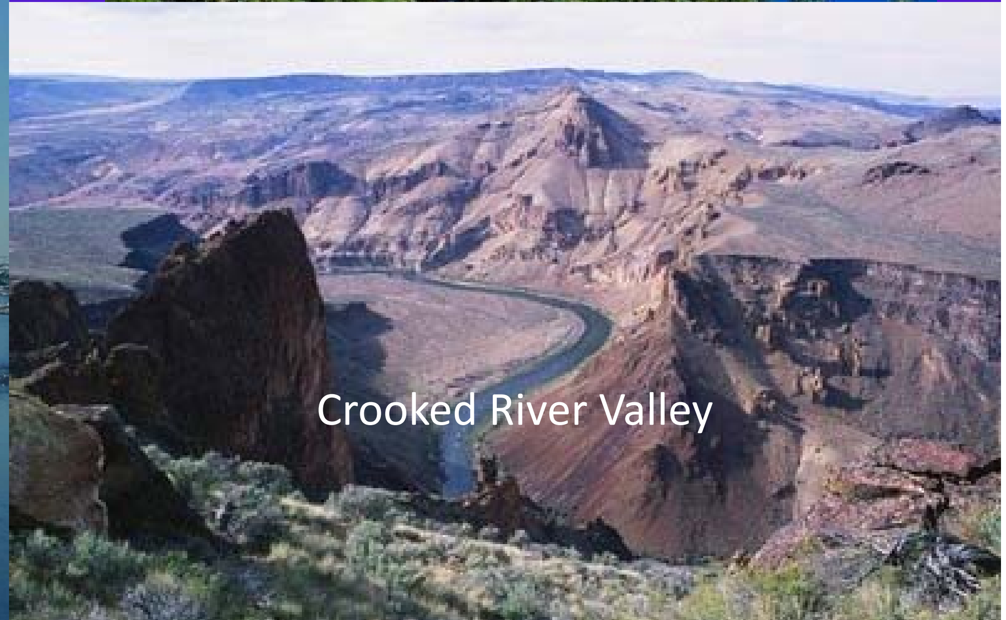
IRCME Lecture
Tokyo University

Oregon: a beautiful state



William Osler says..

- The practice of medicine is an art, not a trade; a calling, not a business: a calling in which your heart will be exercised equally with your head.

Background

- As healthcare costs have risen in the United States, efforts, both by government and private entities, to control costs have focused largely on professional staff and system revision
- Hospitalist movement was created to help improve efficiency, cost saving, and potentially patient outcomes

Background

- General internal medicine has changed,
- The structure of inpatient care in academic and community teaching hospitals in the United States has also evolved.

  The most striking change has been the emergence of the academic hospitalist model.

  Currently, Hospital Medicine is one of the fastest growing careers in internal medicine in the United States.
- Faculty (usually general internists) focus a substantial amount of their time and energy on the care of inpatients.

Goals of this Talk

- Explore the history, success, and challenges of this movement, focusing on
  - patient care
  - education
  - research
  - career viability
- Understand the roles and responsibilities of an academic hospitalist

Why of interest to Japan?

- Hospitalists are now one of the main sources of patient care and medical education in US training programs in the United States

- As Japan builds general internal medicine education programs, it may consider adopting components of the hospital model within public and private teaching centers

Overview

- What is a hospitalist? Why was it created? State of the Field: What do they do?
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  - Evidence Summary
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- Career Challenges
  - Mentoring and Promotion
  - Academic Development and Barriers
- Resources and Opportunities
  - Academic Hospitalist Taskforce
  - Research
- The Future

What is a Hospitalist?

- 1996: In a *New England Journal of Medicine* article, Dr. Lee Goldman and Dr. Robert Wachter coined the term "hospitalist."
- "Official" Definition

"Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients; activities include patient care, teaching, research, and leadership related to hospital care"

-Society of Hospital Medicine

Internal Medicine, Pediatrics, Family Medicine

- Practical Definition

"Are you a hospitalist?" Yes = hospitalist

- Future Definition

American Board of Internal Medicine added qualification?

Why this model?

- More efficient system
- Attention can be paid to the unique needs of the hospitalized patient
- A hospitalist can be more readily available to a patient than a doctor who spends much the day outside the hospital in an office or clinic setting

Why were Academic Hospitalists Programs Started?

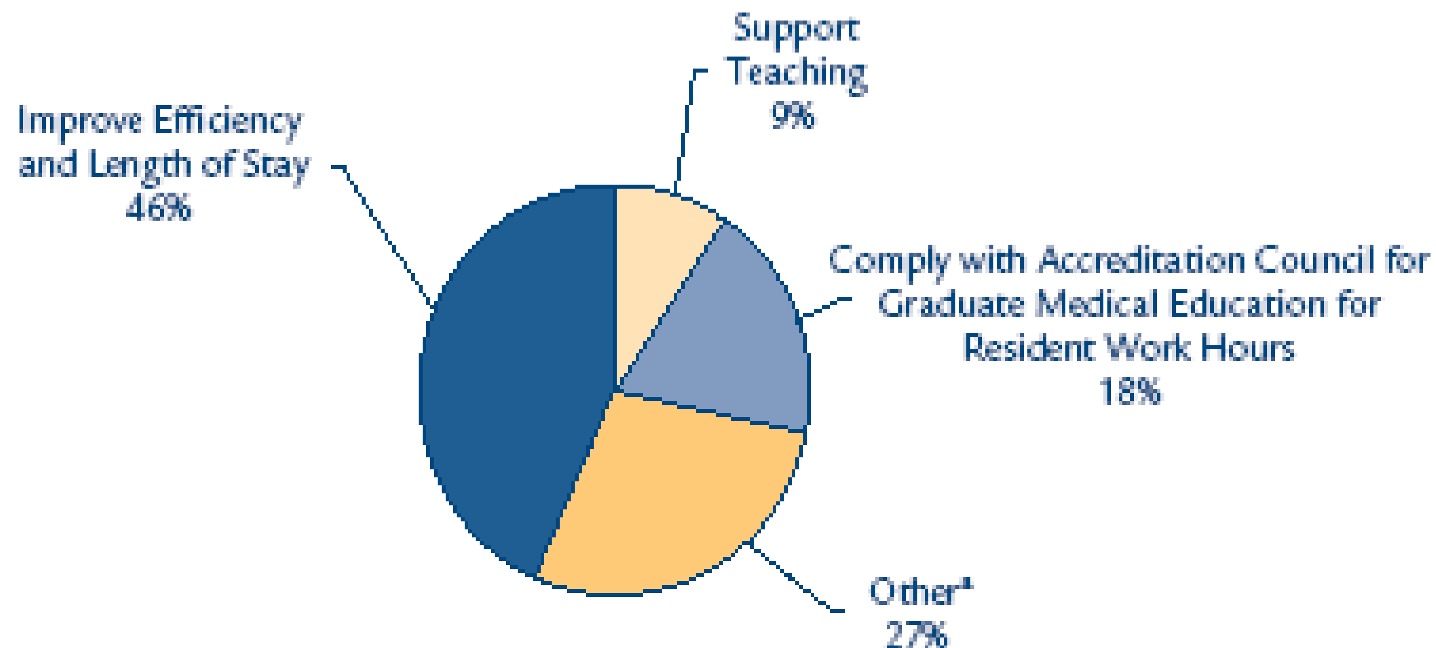


Figure 1 – Source: Characteristics survey results

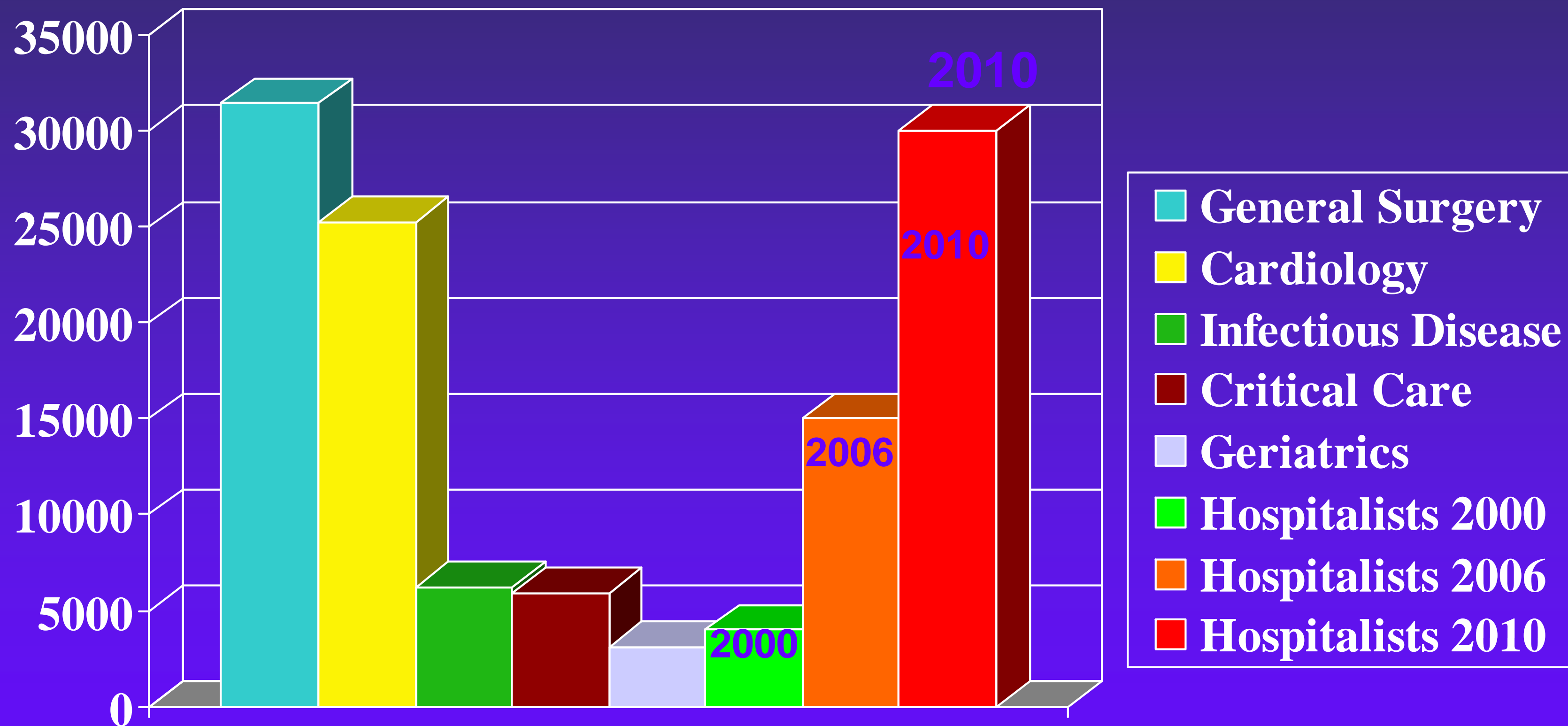
*"Other" is mostly a response that includes more than one of the other options.

UHC Consortium 2006

Hospital Medicine History from The Society of Hospital Medicine (SHM)

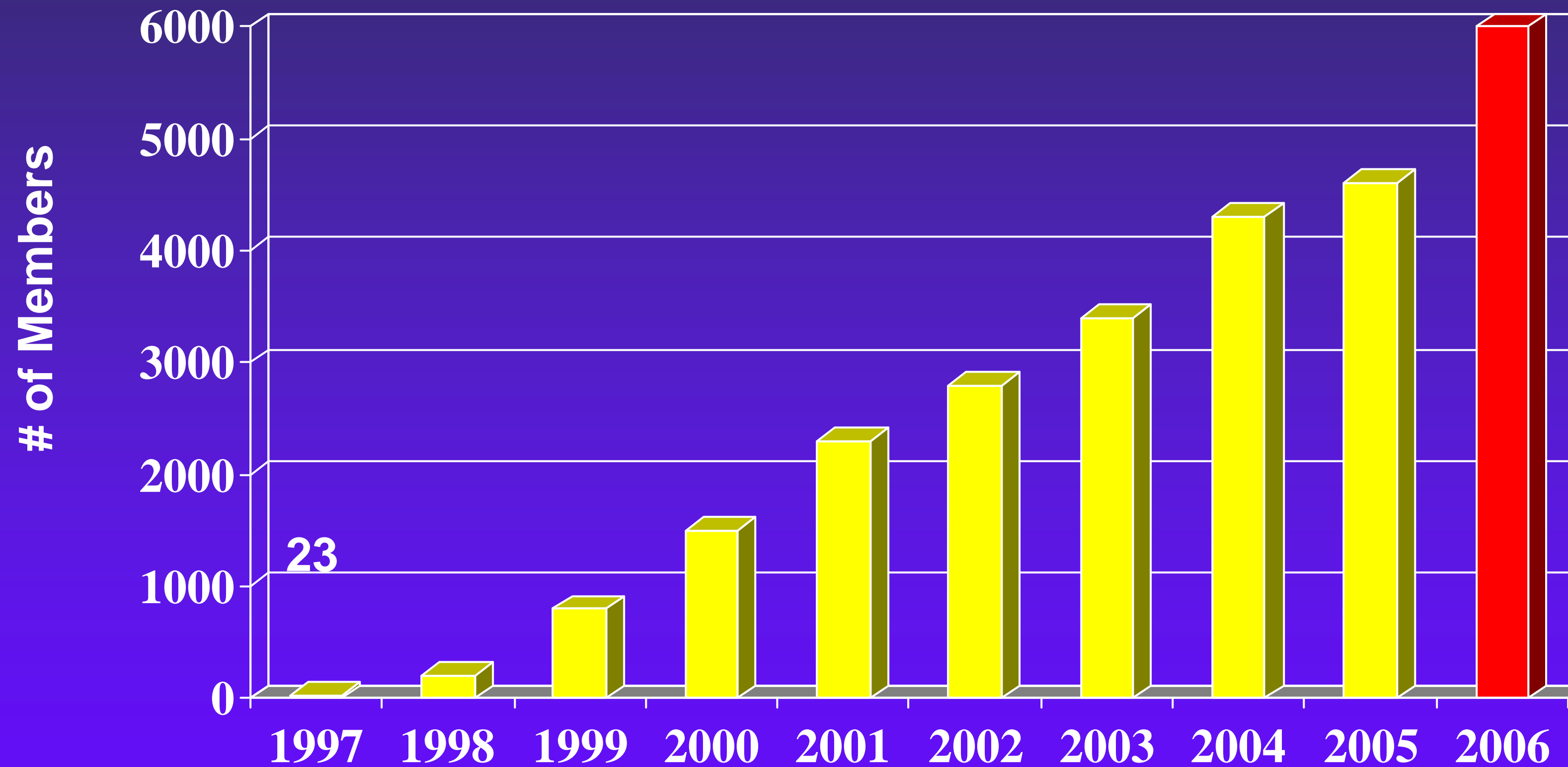
- **2004 (April):** SHM's Annual Meeting attendance tops 1,000 for the first time.
- **2005 (January):** SHM hosts its first Leadership Academy.
- **2005 (Spring):** SHM's membership surpasses 5,000.
- **2006 (February):** SHM launches the Journal of Hospital Medicine (JHM). Indexed by Medline, JHM is the first peer-reviewed journal devoted exclusively to hospital medicine.
- **2006 (May):** SHM launches its online Career Center.
- **2007 (March):** Projections based on the 2005 Survey by the American Hospital Association state that over 20,000 hospitalists are practicing in the United States.
- **2010: SHM projects that the number of hospitalists practicing in North America will surpass 30,000.**

Number of U.S. Physicians



*Lurie, *Am J Med*, 1999

Society of Hospital Medicine Membership



Quote from Society of Hospital Medicine

- *Hospital medicine is a significant career path option for those trained in general internal medicine, general pediatrics, family practice, and obstetrics.*

- *There are more new jobs available for hospitalists than in any aspect of internal medicine.*

Academic Hospitalists

- Major Teaching Hospitals
  2/3 have hospitalist programs
  Average 17 hospitalists / program

- 27 Chiefs of GIM
  25 have hospitalists
  Median Size: 12 (range 1-50)
  Years on faculty: 4 (range 1-12)
  >80% planning for growth

Academic Hospital Medicine 2003 Survey

- 5000 U.S. Hospitals

  1/3 have hospital medicine groups

  2/3 have hospital medicine groups if >200 beds

  3/4 have hospital medicine groups if >500 beds

Kralovec, et al. JHM 2006

- 100% of hospitals on US News and World Report 2006 Honor Roll of America's Best Hospitals

Academic Hospitalists
What do they do?

- Clinical Care Delivery
  - Inpatient Medicine Wards / Observation units / Emergency Medicine Triage
  - Consults / Surgical Co-management
  - Palliative Care
  - Clinics (pre-operative clinic, urgent care clinic, post-discharge follow up clinic)
- Quality improvement (QI) and Patient Safety
- Teaching Medical students, Residents, and others
- Administration (clinical, quality improvement, teaching, Residency Program leadership)
- Research

Academic Hospitalists

Hospitalist Roles: Chiefs of GIM

- Inpatient Wards 100%

  70% are on non-resident services

- Other roles

  Education 89%

  Consultation 85%

  Hospital Committees 84%

  Research 54%

  Clinic precepting 27%

  Personal clinic 8%

What kind of training does a hospitalist need?

- 85% - of practicing hospitalists trained by standard internal medicine residency
  - 4 yr undergraduate, 4 yr medical school, 3 yr residency
  - Majority of US Internal Medicine Residents train in the hospital
- 5% - subspecialty fellowships, pulmonary/critical care most common.
- Hospitalist residency
  - Hospitalist tracks - part of an internal medicine residency programs, with end-of-life care, quality improvement, and medical consultation
- Fellowship training programs - research training, teaching skills, and additional clinical experience

Academic Hospitalists

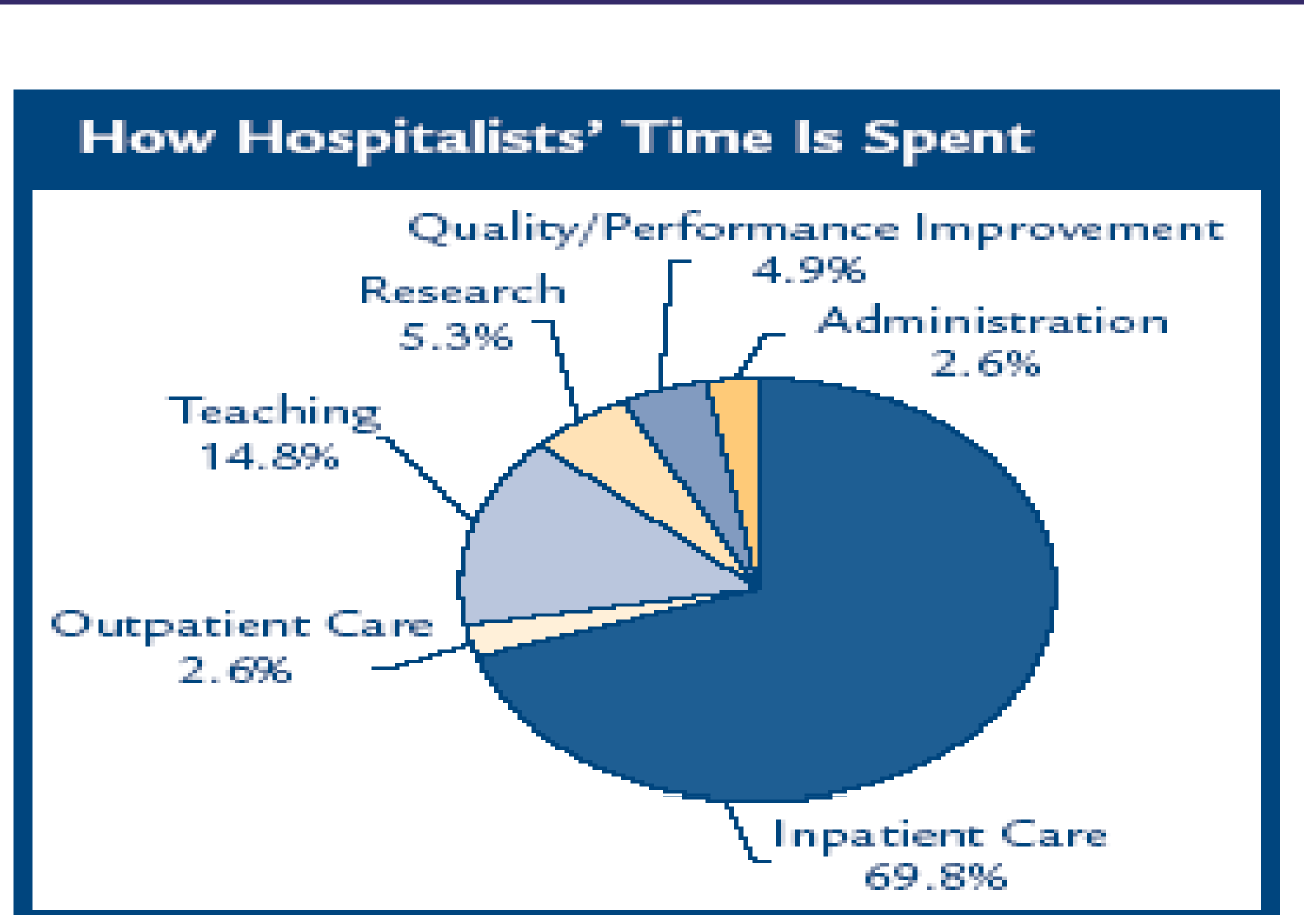


Figure 3 – Source: Characteristics survey results

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Impact on Patient Care

- Smaller group of dedicated clinicians provide hands-on care of hospitalized patients, leadership in important areas of hospital operations, and quality improvement

“Example is not the main thing in influencing others. It is the *only* thing”

Albert Schweitzer MD

Nobel Peace Prize 1952

Example case of patient care before hospitalists

Ex. Case before hospitalists

- Dr Smith rounds on his 4 hospitalized patients at 6:30 am and gets to clinic by 8:15 am.
- A page at 10 am to Dr Smith relays that his patient in the hospital is having chest pain; he looks at the EKG by fax; his patient is having a myocardial infarction.
- Dr Smith quickly leaves the clinic to transfer his patient to the ICU. His clinic patients either wait for Dr Smith, go to the emergency room, or cancel their appointments.
- While at the hospital , a nurse stops Dr Smith to discuss the abdominal pain on another patient. He then talks to a family member of a third patient that he's been trying to meet to discuss end of life decisions. He is too late for clinic to discharge another patient so he decides to do it tomorrow.

Example case continued

- Dr Smith returns to clinic an hour and 45 minutes later. His clinic patients are frustrated because they have waited so long. He is 5 patients behind schedule now. The inpatient pharmacy calls him to discuss his order on the patient with abdominal pain during a clinic visit.
- He won't be home until 9:00 pm tonight after charting notes. He will miss his daughter's soccer game, and forget that today is his wedding anniversary.

Consequences

- Benefits: Dr Smith's hospitalized patients receive care from their primary doctor
- Drawbacks:
- Dr Smith has lost revenue by missing clinic patients
- Dr Smith's patients have waited a long time for him to return, interrupted clinic visits
- Dr Smith's hospitalized patients needed quicker attention, to be discharged that day
- Dr Smith appears overworked

Example Case After Hospitalists

Example case with hospitalist

- Dr Allen is a hospitalist. She rounds on her 16 hospitalized patients starting at 7 am; 4 of those patients are Dr Smith's.
- Dr Allen receives a call at 9:30 am that a patient is having chest pain. Dr Allen goes to the bedside of the patient, examines them, sees the EKG, calls cardiology, starts heparin, transfers the patient to the cath lab by 9:45 am.
- Dr Allen sends a message to Dr Smith to inform him of the patient's MI and that another patient will be going to hospice care in the morning. She discharges the other patients of Dr Smith's that afternoon.
- Dr Smith sees all of his clinic patients undisturbed, gets an update on his hospitalized patient's status and gets home to see his family by 6 pm, just in time for his daughter's soccer game with a bouquet of flowers in hand, for his wife.

What does this provide?

- Benefits
- Efficient flow in the clinic and hospital and therefore revenue
- Allows the primary care doctor to focus on clinic care and the hospitalist to focus on patient care
- Quicker attention to acute issues in the hospitalized patient, leading perhaps to better outcomes
- Efficient admissions and discharges, saving money

Drawbacks and Challenges

- Drawbacks
- Dr Smith's patients don't know or trust Dr Allen and may wish to see their primary care doctor, Dr Smith
- Dr Allen may not know certain aspects of these patients' medical issues or preferences, only known to Dr Smith
- Challenges
- Reluctance to relinquish inpatient care
- Need trust and willingness to give feedback to colleagues
- Reliable communication between in patient and outpatient doctors – smooth transitions of care take time and effort!

Summary of Impact of Hospitalists on Patient Care

- Several studies demonstrate both length of stay (LOS) and cost per case (C/C) are reduced through the use of hospitalists
- On average, hospitalists reduce LOS by 16.6% and C/C by 13.4%

  Both academic and community-based institutions
- Improve overall efficiency

  Admission cycle time decreased from 147 minutes to 18 minutes J Gen Intern Med 2004;19:266-268

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Traditional Model

- Training in internal medicine and pediatrics had residents on hospital rotations caring for patients who, lacking a private physician to direct care, were assigned to the ward service and a ward attending
- The resident would contact all other patient's PCP's for guidance
- The ward attending provided patient care on a rotating basis along with other duties in the lab, clinic or subspecialty office
- Some doctors "did it all"
- The ward attending knew only a few residents well

Hospitalist Model

- A group of generalists assume care for the majority of inpatients and contribute substantially to the training of medical students and house staff
- A smaller group of dedicated teaching clinicians provide focused teaching of medical students and resident trainees
- Provide continuity to education, get to know the personalities and educational needs of learners well

Case
Rounding with Residents
Traditional Model

Rounding before hospitalist

- Resident Jones is a very busy 3rd yr Internal Medicine resident who is caring for 12 very sick patients. Dr Mack, her attending, only attends on GIM one month per year, but is otherwise doing research. He arrives and starts rounds about 45 minutes late.
- Resident Jones has tried to talk with all 12 of the patient's primary care doctors to get advice about their conditions but didn't get in touch with all of them.
- Dr Mack confesses he doesn't feel comfortable with all of the issues of the patients, as he is mainly a researcher on hyperlipidemia, so he asks for many consults.
- Dr Mack isn't sure what to teach today so he gives a short lecture about his latest research. Resident Jones falls asleep.

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Rounding with a Hospitalist

- It is a post call day. Dr Sullivan has arrived to the hospital at 7 am and is waiting for his team to begin rounds. He has already reviewed the cases from home the night before so is aware of most of the issues on these patients before rounds.
- The team was wondering if a patient had Wegener's Granulomatosis and Dr Sullivan was able to bring in a recent article on how to diagnose this condition and provide several teaching points.
- After the team leaves the hospital (duty hours) Dr S calls PCP's, consults, and meets with patients' family members.
- Dr Sullivan does physical diagnosis rounds with medical students in the afternoon.
- Dr Sullivan rides his bike home by 6 pm to be with this daughter to go rock climbing

What does this provide to learners?

- Benefits
- Access to a readily available faculty member who is comfortable and knowledgeable about hospital medicine and how to get work done in the hospital
- Access to a faculty member who is able to teach about topics that match the needs of residents
- Relieves faculty who may not desire to attend in the hospital but who can focus in the outpatient or research setting
- Ability to comply with duty hours
- Potential work-life balance for Hospitalists
- ? Less burnout
- Drawbacks
- Less resident autonomy in patient care decision making?
- Transitions of care

Summary of the Impact of Hospitalists on Education

- Evaluated in a number of studies involving both internal medicine and pediatric training programs

- These studies have similarly reported that the house staff and student educational experience with hospitalists is at least as good if not better than traditional attending models

Academic Medicine, Vol.79,No.1 A. Hunter, S.Desai, R.Harrison, Chung

Summary of the Impact of Hospitalists on Education

- Hospitalists as inpatient attendings lead to higher levels of house staff satisfaction with their inpatient rotations
  1. more available to residents and students
  2. make better use of evidence-based medicine
  3. emphasize cost-effective care
  4. give better feedback

Availability of attending

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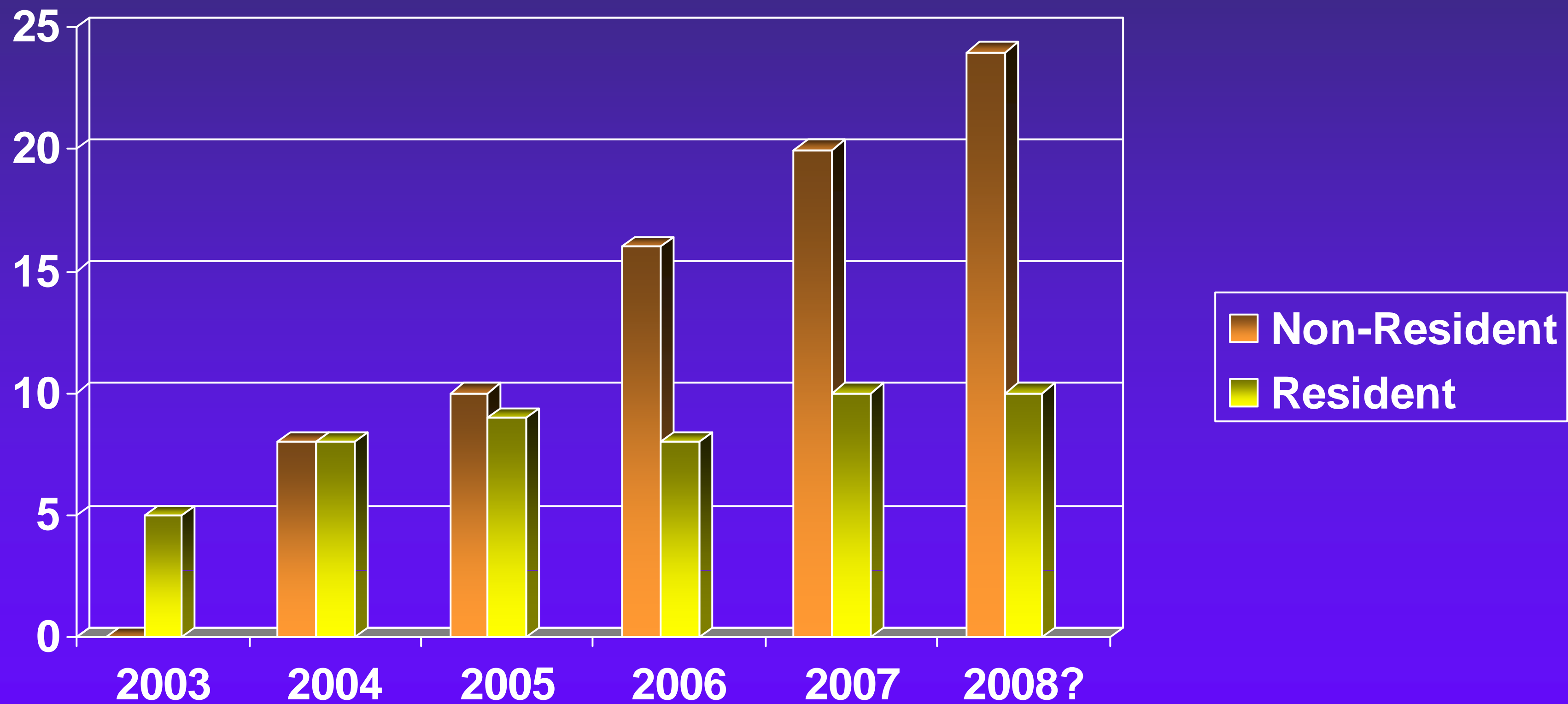
Non-Resident or “Non Teaching” Services in Academic Medical Centers (AMCs)

- Most AMCs have these faculty
- Shift based
- Nights / Weekends
- High volume
- Little “education” mission
- No research
- Perceptions: Third-class academic citizens
  - Beneath specialists and generalists with residents
  - “4th year medicine residents” doing “intern work”
  - “Pretendings”

Case of Career Challenges for “Nonteaching” Hospitalist

- Dr Hull is right out of her residency and was hired as a “non teaching” hospitalist at her local university. She has been in her position for 3 yrs. She mainly does internal medicine consultations and surgical co-management ,working nights and weekends. She finds her job very busy and feels like a “super resident.” She gets very little mentoring from her seniors. She isn’t sure how she is going to sustain this job.

U of M Hospitalist FTEs



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Challenges

Mentoring and Promotion

- Mentoring is critical for success
- Most hospitalists are young, junior faculty
- Most hospitalist program directors are also young
- What is the career path?
- Few tenured “hospitalist researchers”
- Few hospitalist division chiefs

Challenges

Academic Development

- Few training programs
- Few funding sources for “hospitalist research”
  - Quality / Safety
  - Education
  - Diseases not “owned” by a specialty; DVT, C-diff, CAP
    - Compete with specialists for NIH funding
- Medical schools undervalue quality / education research
- Little time to work on scholarship

Challenges

Barriers to Success

- Scholarly activities not well supported

  By Departments, Divisions, Hospitals

- Academic GIM slow to embrace hospitalists
- Lack of leadership / guidance to support academic missions of hospitalists

Academic Hospitalist Survey

- **Methods:** cross-sectional email survey of academic hospitalists at 17 U.S. medical centers
- **Results:** 266 of 420 hospitalists (63%) completed the survey

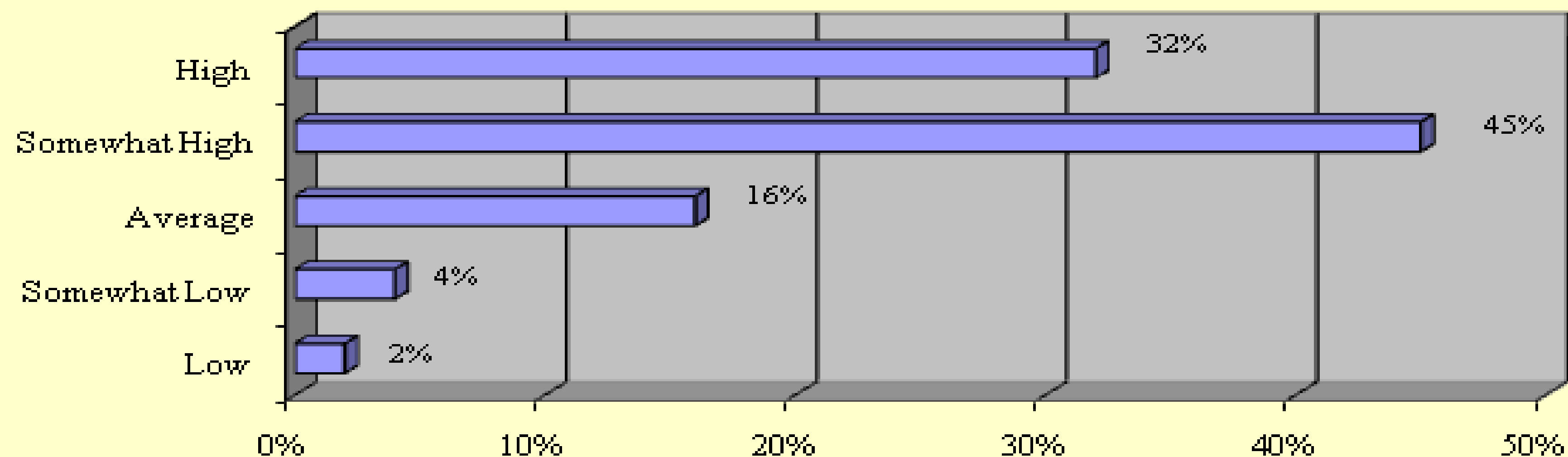
  Productivity and Promotion

  Career Satisfaction and Burnout

  Mentorship and Scholarship

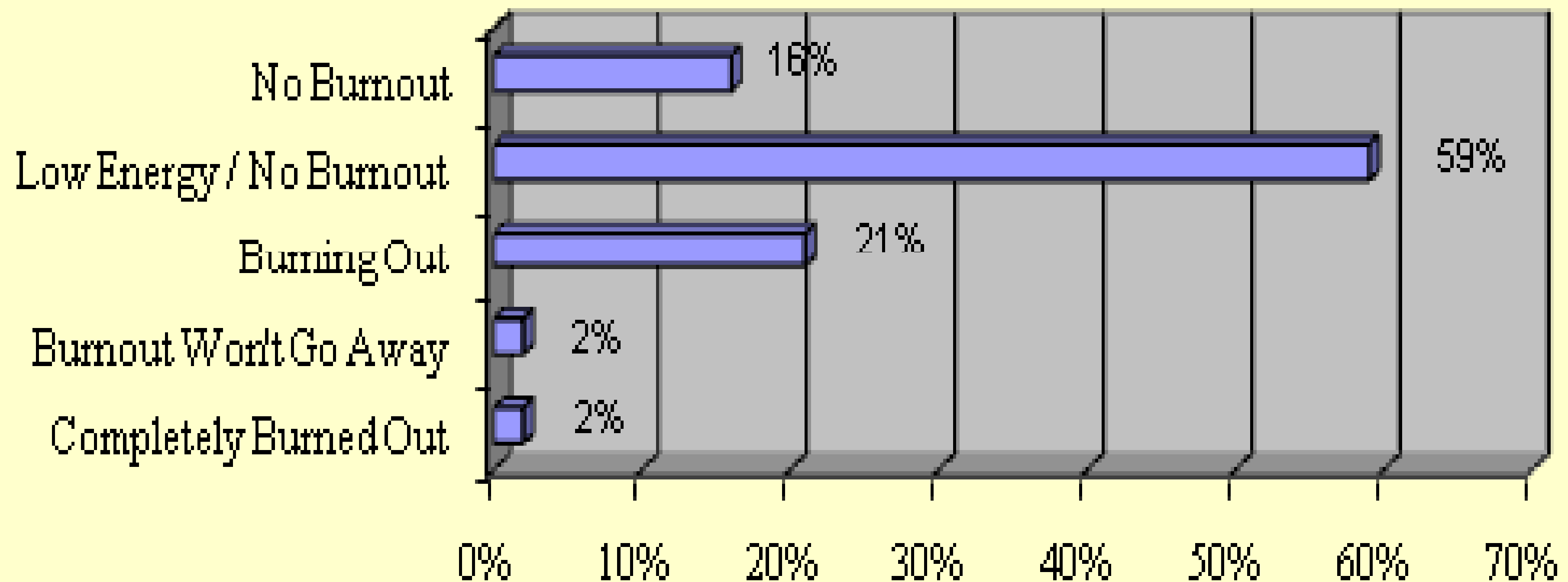
Mark B. Reid, MD, Denver Health Medical Center, Denver, CO, Gregory Misky, MD, University of Colorado Denver, Rebecca A. Harrison MD, Oregon Health & Science University,Andrew Auerbach, MD, University of California, San Francisco, Jeffrey J. Glasheen, MD, University of Colorado Denver

Percentage of Academic Hospitalists Satisfied With Their Current Job



Glasheen JJ[1], Misky GJ[1], Reid MB[2], Harrison RA[3], Sharpe B[4], Auerbach A[4]
[1]University of Colorado Denver, [2]Denver Health Medical Center,
[3]Oregon Health Sciences Center, [4]University of California, San Francisco

Percentage of Academic Hospitalists Experiencing Burnout



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Promotion, Burnout and Mentoring among Academic Hospitalists

- A substantial number of hospitalists trained in internal medicine and working in university hospitals lack the teaching and academic skills that are essential to promotion
- 25% have burnout symptoms
- Majority see the importance of mentoring, but half didn't have a mentor
- Academic hospitalists are satisfied but experience high levels of stress and burnout

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Resources and Opportunities

Academic Hospitalist Working Groups

- American College of General Internal Medicine
  ACGIM
  www.acgim.org
- Society of General Internal Medicine
  www.sgim.org
  SGIM Academic Hospitalist Task Force
- Society of Hospital Medicine
  www.hospitalmedicine.org
  SHM Academic Hospitalist Task Force

Variety of national meetings and summits planned to discuss education and leadership

Opportunities

ACGIM / SGIM Taskforce Recommendations

- Hospitalists need to be embraced
- Create Sustainable Jobs
- Provide resources to support academic pursuits
- Leadership to support / negotiate
- Build resources for mentorship
- Promotion should value education / quality improvement (QI) work

Hospitalists' working place should be our laboratory.
Many questions about hospital care, teaching, and our careers remain to be answered.

Hospital Medicine Research

- Critical to the future success of the field
- A requirement for a "specialty"
- Desperately needed
- Key areas to target include
  - Nosocomial Infections
  - Errors and safety issues
  - Common diseases (CAP, etc.)
  - Translating research into practice
- But how to do it?
  - Bridging with GIM and other departments with established research expertise

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Future Training Models

- University of California, San Francisco, developed a Hospital Medicine track within our traditional categorical program
- Other Universities may follow

Components of the Hospitalist Training Program at UCSF

- Three months elective time in the PGY 2 and PGY 3 years
- Mentoring by hospitalist faculty
- Inpatient medicine journal club
- Group and individual projects, focused on teaching, research and quality improvement
- Special clinical experiences, which include:
  - Time spent in community hospitalist programs
  - Skilled nursing facility
  - Hospice care
- Special didactic curriculum, which includes:
  - End of life care
  - Outcomes research/clinical epidemiology
  - Quality improvement
  - Communication skills
  - Medical consultation
  - The "business of medicine", including managed care
  - How to teach

The Future of Hospital Medicine
Quote by Dr Robert Wachter UCSF

- *The hospitalist field was founded on the premise that inpatient generalists could improve the care of hospitalized patients and systems of inpatient care. In the early years, the challenge was to determine whether the field was indispensable. We now know that it is. The challenge now is that hospitalists are often seen as the solution to all sorts of knotty problems -- virtually none of which are associated with significant professional fee reimbursement. Managing this demand will be the greatest challenge of the field's second decade.*

Future

- Hospitalist now cover for residents who have duty hour restrictions on work hours
- Work-life balance needs to extend to attending physicians as well as to residents
- The special challenge for academic hospitalists is to promote a long and satisfying career in academic hospital medicine and to excel as teachers for all members of the multidisciplinary team

Summary

- Hospital Medicine is one of the fastest growing and now well established fields in the US health care system
- Variety of benefits and challenges impacting patient care, education, and career sustainability
- Hospital Medicine needs to continually reshape itself to meet the clinical, educational, career, and financial demands of the future

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- International Research Center for Medical Education, The University of Tokyo, Tokyo, Japan

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Thank you

How to create a successful Academic Hospitalist Program

Opportunities

The ***Needs*** of a Successful Academic Program

- Great Faculty
  - Could have done anything, but chose hospital medicine
  - People you want to be with
- Program Director:
  - One who has been around the block
  - Leadership role in Division, Department, and Hospital
  - Assistant Director for big / complex programs
- A “rain-maker” / “steward” (or several) for research
  - Hired as a hospitalist
  - Committed faculty within another division (HSRD)
  - Fellowship training

Our Hospitalist Division Chief

Opportunities

The ***Needs*** of a Successful Academic Program

- Human resources
  - Supportive Chair, Residency Director, (and faculty)
  - Division / Department Administrator
  - An administrative assistant (the true “director”)

- Financial resources
  - Faculty development
  - Quality Improvement
  - Meeting presentations
  - Research

Opportunities

Establishing Clinical Excellence

- Develop a clinical niche
- Give clinical lectures to faculty and trainees in other departments
- Grand rounds
- Visit neighboring / smaller institutions to speak
- Present a clinical update at a regional (ACP?) or national meeting

Opportunities

Establishing Teaching Excellence

- Make teaching an active rather than passive process

  Get feedback, work to improve

- Curricular / educational innovation

  Evaluate it!

  Create an "education portfolio"; document your work

- Pursue leadership roles in student / resident education

HOSPITALIST IMPACT ON PATIENT CARE

Ed admission process

- Direct admission to hospitalists
- Admission cycle time decreased from 147 minutes to 18 minutes J Gen Intern Med 2004;19:266-268

Pneumonia

- Shorter adjusted LOS
- Earlier switch to oral antibiotic by hospitalists (1.6 d vs 23 d)
- More patients discharged with unstable clinical variables
- Overall process of care similar
- Mayo Clin Proc. 2002 Oct;77(10):1053-8

Resource utilization and specialty

- Recent inpatient general medicine experience is a determinant of reduced resource use
- Hospitalists showed a trend toward decreased LOS compared to all other physicians (rheum, endo, gen internists,etc)
- 1 year retrospective cohort ; 2617 gen med admissions at U Michigan
- J Gen Intern Med. 2004 May ; 19(5.1) : 395-401