The Hospitalist Movement
Past, Present and Future

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The Hospitalist Movement
Past, Present and Future

- History and evolution of the movement
- Hospital Medicine in 2011
- Current Challenges
- Proposed solutions & Future Initiatives
The term “Hospitalist” was first coined in 1996 by Robert Wachter, M.D. and Lee Goldman, M.D.

“……we anticipate the rapid growth of a new breed of physicians we call “hospitalists” — specialists in inpatient medicine — who will be responsible for managing the care of hospitalized patients in the same way that primary care physicians are responsible for managing the care of outpatients…….”

HOSPITALISTS defined as:

“….Physicians whose primary professional focus is practice of general internal medicine in the inpatient setting…..”
Hospital Medicine & The Hospitalist

- **DEFINITION……Merriam-Webster dictionary (2005)**

  hos·pi·tal·ist  *noun*  häs-(pi-tə-list)\n
  ............a physician who specializes in treating hospitalized patients of other physicians in order to minimize the number of hospital visits by other physicians............

- **SHM (Society of Hospital Medicine)**

  Hospital medicine:

  A medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients.
History

- **1996**
  The term “Hospitalist” is first introduced by Wachter and Goldman.

- **1997**
  National Association of Inpatient Physicians (NAIP) is founded.
  Holds its first meeting (“Management of the Hospitalized Patient” Conference) hosted by UCSF. Nearly 200 were in attendance.

- **1998**
  NAIP holds its first annual meeting with more than 100 attendees and faculty.

- **2003**
  NAIP changes its name to the “Society of Hospital Medicine” (SHM).

- **2004**
  SHM’s Annual Meeting attendance tops 1,000 for the first time.
History

- **2005**
  SHM’s membership surpasses 5,000.

- **2006**
  SHM launches the Journal of Hospital Medicine (JHM). Indexed by Medline, JHM is the first peer-reviewed journal devoted exclusively to hospital medicine.

- **2007**
  Projections based on the 2005 Survey by the American Hospital Association state that over 20,000 hospitalists are practicing in the United States.

- **2011**
  SHM projects that the number of hospitalists practicing in North America will surpass 31,000.
Evolution

Making a case for Hospital medicine

EARLY DRIVERS OF GROWTH

- In 1983, Medicare, the primary payer for inpatient care, switched to a system of diagnosis-related groups (DRG) in which hospitals received fixed payments for given diseases.

- However, Physician reimbursement continued to largely be on a fee-for-service, per-day basis.

- For hospitals the DRG based fixed reimbursements created a powerful incentive to support strategies that could safely shorten lengths of stay (LOS) and decrease hospital costs.

- Until the mid-1990s, these efforts mostly took the form of Care pathways and Practice guidelines and even hiring of non-physician Case managers, whose charge was to look for excessive resource use and prolonged hospitalizations. These strategies had relatively little effect on physicians’ practice patterns.
Evolution

Making a case for Hospital medicine

- The inpatient physician was also the patient’s outpatient doctor and with a per diem payment system there were no financial incentives for shorter LOS.

- Physician had no “alignment of incentives” with the hospital which was operating under the DRG payment system.

- In the early 1990s, some large health systems (Kaiser), particularly those with employed physicians and those who had aligned incentives with their hospitals began to reconsider this dominant model of hospital care i.e. having the same physician serve as inpatient and outpatient attending.
Evolution

Making a case for Hospital medicine

- On analysis of this model, they realized:
  - that inpatients per physician were fewer
  - patients were increasingly sick
  - physicians were busier than ever in their offices
  - acute care medicine was becoming more complex and faster paced
  - and that the old system was unlikely to lead to efficient hospital care.
  - On-site availability of a dedicated inpatient physician would likely lead to improved quality, efficiency and throughput.

- These few forward-thinking organizations began to reorganize their hospital care, dichotomizing the inpatient and outpatient work between two physicians.

- The **Hospitalist model** of care was born.
More recent drivers for growth....

the “Quality” issue

- ROI or “Value = Quality/Cost”

- Initial drivers were economic – enhancing value by reducing costs.

- In late 1999, the Institute of Medicine (IOM) published “To Err is Human”, and 2 years later “Crossing the Quality Chasm”

- These reports highlighted the issue of medical mistakes (particularly in hospitals) and poor quality and marked variations of care in the US and placed them on the public’s radar screen.
More recent drivers for growth.....

.......Quality and Patient Safety.......

- To address these issues the public, media and Government focused on Hospitals.

- Hospitals felt the need to have a cadre of physicians whose focus was not just the science behind health care but also “the way it was delivered”.

- They wanted physicians who were
  - receptive to new models of care
  - sensitive to quality & safety issues in hospital health care delivery.
More recent drivers for growth.....

......Quality and Patient Safety......

- Physicians who:
  - practiced evidence-based medicine
  - were enthusiastic about systems thinking and teamwork and
  - were familiar with the intricacies of health care delivery
    in the hospital setting.

- Hospitalists – physicians whose financial and professional
  interests were aligned with those of the hospital were ideally
  suited for this role.

- Having a strong hospitalist presence was both economically
  advantageous and a key factor in the quality and safety
  revolution that was permeating the American health care
  system.
Other catalysts of growth

- **Filling the workforce gap:**
  - 2003 – ACGME Resident duty hour restrictions
  - Teaching hospitals primarily affected
  - Creation of “uncovered” or “non-teaching”
    Hospitalist run services to handle the patient volume.

- **Education – “Academic Hospitalists”**
  - dedicated inpatient clinical teachers
  - experts at inpatient medicine with a focus on quality & patient safety, practice of cost-effective and EBM and proponents of safe transitions of care.

- **Surgical Co-management**
  - Perioperative Medicine Consultative services
Foundation of Hospital Medicine

- **Who**
  
  Inpatient IM trained Physicians dedicated to the general medical care of hospitalized patients.

- **Why**
  
  - Economic impact – reducing costs
  - Quality and Safety imperative
  - Hospital clinical service demands across multiple specialties
  - Educational Value
“Their style is fast paced, their work ethic intensely focused, and they can shave a day off your average hospital stay in a single shift. They are the hospitalists. This emerging specialty is currently sweeping the country faster than the Chicago Bulls swept the 1995 NBA season”.

- Physician's News Digest
  February 1998
....and then there were the skeptics

- What about continuity of care?
- How was the PCP-patient relationship affected?
- Would their presence affect the PCP’s income?
- Would hospitals impose use of hospitalists by PCPs?
- Would specialists get lesser consult referrals?
- Do hospitalists really save hospitals money?
- Did quality and safety actually improve?
- How do resident trainees view hospitalists as clinical teachers?
## Proving value

<table>
<thead>
<tr>
<th>Study</th>
<th>Hospital costs</th>
<th>ALOS</th>
<th>Outcomes Mortality</th>
<th>Outcomes Readmissions</th>
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<tr>
<td>Wachter et al, 1998</td>
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<td>Moffitt-Long Hospital, UCSF</td>
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<tr>
<td>Moffitt-Long Hospital, UCSF</td>
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<tr>
<td>Diamond et al, 1998</td>
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<td>No change</td>
<td>54% decrease</td>
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<tr>
<td>Western Penn Hospital, Pittsburgh</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kroger and Grant, 1998</td>
<td>4% lower</td>
<td>26% shorter</td>
<td>Lower in control group</td>
<td>Not reported</td>
</tr>
<tr>
<td>West Suburban Med Ctr, Oakpark, IL</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Stein et al, 1998</td>
<td>5% lower (HS)</td>
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<td>Freese, 1999</td>
<td>25% lower</td>
<td>0.64 day decrease</td>
<td>Clinical outcomes not reported</td>
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<tr>
<td>Park Nicollet Med Ctr, Minneapolis</td>
<td></td>
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<td>17% shorter</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Long Island Jewish Med Ctr</td>
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## Proving value......

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<th>Outcomes</th>
</tr>
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<tbody>
<tr>
<td>Davis et al, 2000 North Mississippi Med Ctr, Tupelo</td>
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<td>Halpert et al, 2000 Brigham and Woman’s Hosp, Boston</td>
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<td>Hackner et al, 2001 Cedars-Sinai Med Ctr, LA</td>
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<td>Kearns et al, 2001 Santa Clara Valley Hosp, San Jose, CA</td>
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<td>No change</td>
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<tr>
<td>Palmer et al, 1999 and 2001 West Virginia Univ Hosp, Morgantown</td>
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<tr>
<td>Meltzer et al, 2001 University of Chicago Hospitals</td>
<td>4% lower</td>
<td>7% shorter</td>
<td>15% decrease</td>
<td>No change</td>
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</table>
Conclusions

Trainees reported more effective teaching and more satisfying inpatient rotations when supervised by hospitalists.

This analysis suggests that hospitalists may possess or accrue a specific inpatient knowledge base and teaching skill that distinguishes them from non-hospitalists.
Hospitalists and PCPs….problems?

Conclusions

Practicing primary care physicians have generally favorable perceptions of hospitalists' effect on patients and on their own practice satisfaction, especially in voluntary hospitalist systems that decrease the workload of primary care physicians and do not threaten their income.

Primary care physicians, particularly internists, are less accepting of mandatory hospitalist systems.
Evolving role of the Hospitalist

- Educator
- Clinician
- Rounder
- Quality guy (Qualitician)
- Medical Consultant
- Care Coordinator
- Family Counselor
Evolving role of the Hospitalist

Certain “off-label” uses -

- ER Triage
- Hospital Transfer Coordinator or “Bed Czar”
- “House-doctor”
  - after-hours coverage for specialty service areas, ICUs, “step-down units” and SNFs
Evolving role of the Hospitalist

- Rise of the “Hyphenated – Hospitalist”
  - Cardiology-hospitalists
  - Oncology-hospitalists
  - Hepa-hospitalists
  - Perioperative hospitalists
  - Night-hospitalists or Nocturnists
  - Holiday-Weekend hospitalist or “Holiweekendalist”

- Hospitalists in other specialties
  - Pediatric and Med-Peds Hospitalists
  - Neurology hospitalists
  - Geriatric hospitalists
  - Surgicalists
  - Laborists
  - Oto-hospitalists
Hospital Medicine in 2011

- Estimated 31,000 hospitalists nationwide
- ~ 65% of the Hospitals in the U.S. have established Hospitalist Programs
- 90% - Adult Hospitalists
  - 85% IM trained, 5% Subspecialty trained
  - 3% FP, 3% Med-Peds, 4% NP/PAs
- 10% - Pediatric Hospitalists
- 8% of IM residency graduates enter hospital medicine
All 14 of the US “Top 14 Hospitals” listed in the 2010-11 US News & World Report have active Hospital Medicine Programs

Barnes-Jewish Hospital/Washington Brigham and Woman’s Hospital, Cleveland Clinic 
Duke University Medical Center 
Johns Hopkins Hospital, Baltimore 
Mayo Clinic, Rochester 
Massachusetts General Hospital, New York-Presbyterian University Hospital of Columbia and Cornell 
Ronald Reagan UCLA Medical Center 
University of California, San Francisco 
University of Michigan Hospitals, Ann Arbor 
University of Pennsylvania, Philadelphia 
University of Pittsburgh Medical Ctr 
University of Washington Medical Ctr
Hospitalist Movement
1996 - 2011

- Value and purpose of hospitalists for hospitals and other stakeholders seems well established.

- Future of Hospital Medicine appears promising with 15 years of unbridled success.

- It is considered the fastest growing specialty in US medical history
Hospital Medicine Success.....

- Development and recognition as a Specialty
  - Unprecedented and exponential growth
  - About a dozen fellowship programs & a handful IM Residency training programs with a Hospitalist track
  - Tremendous name recognition
    (a Google search on “hospitalist” produces approx. 2.8 million entries, and a Pubmed search yields approx. 1300 articles)
  - Two textbooks
    (Hospital Medicine and Comprehensive Hospital Medicine)
  - A published list of core competencies through SHM
Hospital Medicine Success............

............and the Challenges

- Development and recognition as a Specialty
  - A thriving professional society (Society of Hospital Medicine) with about 11,000 members
  - An exclusive journal (Journal of Hospital Medicine)
  - but still lacking a well defined “skill-set”

- Recognition as a focused practice discipline

In 2009 the ABIM and ABMS approved designation through a “Recognition of Focused Practice” to be achieved through the Maintenance of Certification process
Yet all is not well......

...the Challenges

- Despite such remarkable growth and success......

- There are also several reports of many Hospitalist programs malfunctioning and failing across the country.

- The explosive growth of Hospital Medicine has also exposed weaknesses that threaten.............
  
  .......the economic vitality of the specialty
  ......the quality of patient care
  ......and the central role of Hospital Medicine in the 
  US healthcare delivery system
Challenges .......... “Growing pains”

- **Physician Shortage**
  - Hospital Medicine well established as a valuable “site-based discipline” for hospitals
  - Explosive growth → Demand > Supply
  - Current estimates suggest a need for ~ 50,000 hospitalists

- **Recruitment and Retention problems**
  - a constant concern for hospitalist programs
    - Desperate recruiting efforts have led to a less selective approach in recruitment that has often resulted in employment of “short-termers” instead of “career hospitalists”
    - “short-term” hires → high turnover → hampered development
Challenges............Infrastructure

- Inability to recruit to meet growing needs (50% of the programs)
- Lack of Physician Leadership
- Lack of clinical and ancillary support (physician extenders/case managers) for patient care to run productive and highly performing hospitalist programs
- Little respect amongst medical fraternity

Source: Hospitalist Management Resources
Clinical Advisory Board Interviews
Challenges........Economic Viability

Revenue pressures

- Physician shortages naturally have the effect of choking one important source of revenue: hiring additional providers to grow the practice.

- Competition for the shrinking pool of physicians drives compensation packages upward.

- This increased economic burden impacts the sustainability of many practices.
Challenges............Job Satisfaction

“Off-label” use/misuse or abuse

- Hospitalists at times face employment pressures of over-extending their clinical roles (night coverage, SNF coverage etc) → perpetuates the “house-doc” role.

- Being asked to manage problems beyond their expertise and training (covering ICUs, complex surgical patients, co-management)

- Excessive workloads and ever expanding clinical roles (some of which they may not be adequately trained to do) cause an “inability to maintain a well-defined identity”

  ↓

  Poor job and career satisfaction

  ↓

  “Hospitalist burnout”
Career satisfaction has become a critical issue for the hospital medicine specialty.

In a SHM’s 2005 bi-annual survey, hospital medicine leaders were asked to rank the top challenges their groups face.

Many of the major concerns relate to career satisfaction.

1. Work hours/work life balance 42%
2. Recruitment 35%
3. Daily work load 29%
4. Expectations/demand from hospital 23%
5. Reimbursement and collections 17%
6. Professional respect and job satisfaction 17%
7. Career sustainability 15%
8. Retention 15%
9. Quality of care/quality indicators 13%
Hospital Medicine......

......a victim of it’s own success?

Explosive Growth
Excess Demand &
Physician Shortage

Demand/Supply mismatch

Hospitalist Burnout &
Attrition

Short-term Recruitments
Hospitalist Misuse
Unsustainable compensation packages
Hospital Medicine

#1 Problem................Recruitment

- There is a growing demand for hospitalists by hospitals nationwide at every level of care (AMCs, Suburban Community Hospitals, LTACHs and Rural Hospitals).

- Emergence of Hospitalists among different IM specialties and other disciplines.

- The supply of long-term Internal Medicine "career hospitalists" remains questionable.
Hospital Medicine

#1 Problem ....................Recruitment

- Over the past 15 years HM as a “hospital-based specialty” has tried to respond to the changing landscape of an increasingly complex hospital environment and in the process has been repeatedly challenged to redefine itself.

- For practicing hospitalists it has been confusing and frustrating often leading to poor job satisfaction, low morale and career changes.
There is a need to revisit the principles and practice of Hospital Medicine.

If HM continues to expand it’s scope of practice based upon evolving hospital based needs, the training of hospitalists and their core competencies will have to be redefined.

Creation of dedicated Hospital Medicine Residency training tracks or separate training programs.

Only then will the genuine “Career hospitalist” emerge.
Hospital Medicine
#1 Problem................Recruitment

- If the care of patients across the nation’s hospitals is going to predominantly be led by hospitalists......

- .......it is an imperative to promote and cultivate long term career interests in hospital medicine amongst residents and medical students.

- There is an obligation in the medical education community to prepare the next generation of health care providers to meet this hospital based workforce need.
Hospital Medicine as a career?

- What are the motivators to become a hospitalist?
- What can be done to make this area of medical expertise more attractive as a career option for future physicians?
- Can Hospital Medicine compete with other subspecialties as a career choice?
Hospital Medicine as a career?

**Favorable**
- Hospital based specialty
- Defined hours with shift work and no call
- Flexible scheduling
- Salaried employment reduces the risk of declining reimbursement (in some cases)

**Unfavorable**
- Relatively young specialty with NO WELL-DEFINED CAREER PATH yet.
- Not Organ specific and requires superior all round medical knowledge (which to many may seem daunting and be a disincentive).
- It is a tough and medically challenging line of work.
Hospital medicine as a career?

**Favorable**

- Minimal practice management responsibilities
- Cognitively challenging
- Emphasis on overall care of the medical pt. which some may find more satisfying
- No long term care responsibilities

**Unfavorable**

- No patient practice of your own
- No continuity of care
- No control over patient characteristics (frequent fliers, chronic pain pts. on narcotics)
- Burnout potential high due to acuity of pt. care and continuous inpatient ward work
# Hospital medicine as a career?

<table>
<thead>
<tr>
<th>Favorable</th>
<th>Unfavorable</th>
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</thead>
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<tr>
<td>Focuses on quality and hospital systems process improvement (brings variety to the profession)</td>
<td>Financial compensation not as good as some medical subspecialties</td>
</tr>
<tr>
<td>Provides an opportunity to enhance medical skills and experience in management of very complex case scenarios</td>
<td>Medicolegal circumstances are unique as hospitalists are involved in a variety of clinical situations – both medical and surgical</td>
</tr>
<tr>
<td></td>
<td>Not enough “procedural action”</td>
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</tbody>
</table>
Possible Solutions

- Broaden and establish a specific skill-set for hospitalists and even create dedicated training tracks to enhance their repertoire.

- Residency training is missing the mark for the skills important for the internist who will practice hospital medicine as a career in “today’s hospital environment”.

  Quality improvement, transitions of care, communication skills, palliative care, multi-disciplinary team leadership, medical care of surgical patients, Critical care skills, medical documentation, coding & billing, hospital finance, IT etc.
Possible Solutions

- Bring VARIETY to the specialty

To enhance career satisfaction will need to develop diversity in their work – clinical, research, administrative, education, hospital service, QA, IT.

Will need financial assistance from hospitals to support their time and effort off the wards.

- Define career paths in hospital medicine.

- Increase recognition amongst the medical fraternity through reward and promotion.

- Enhance compensation to make it as attractive a career choice as other medical subspecialties
Possible Solutions

- **Development of Work environment & Infrastructure**
  
  Improve work-flow design, scheduling and leverage EMR technology to enhance productivity and charge capture.

- **Development of Non-Physician Provider Medical services**
  
  - There is a talent pool of 65,000 PAs and 120,000 NPs in the U.S. today
  
  - Hospitalists do not function in a vacuum
  
  - Appropriate use of ancillary personnel (care coordinators, case managers, social workers etc)
  
  - Will help elevate their efficiency, productivity and job satisfaction
Possible Solutions

- Redefine Hospital medicine training
- Bring variety into the profession
- Define Career paths
- Develop and redesign their work environment
- Develop and expand the Non-Physician Provider role
- How do you enhance a specialty to make a bigger “qualitative” impact?
Some final thoughts......

- Hospital medicine has definitely arrived and is here to stay.

- It’s a discipline which has developed out of medical trends similar to Emergency Medicine and Critical Care Medicine and is a “site-based” specialty mostly practiced by internists.

- In the past 15 years it has proven to become a value-added service in the increasingly complex world of acute care medicine.
Some final thoughts......

- The key stakeholders – hospitals, health plans, payers, PCPs, other specialty colleagues, surgeons, Residency program directors, resident trainees, medical students and even patients.......all seem to appreciate the value of hospital medicine and have accepted the concept.

- Going forwards, with the advent of “Value-based Purchasing” and “Pay for Performance” initiatives, hospitalists will play a central role in shaping the Patient’s hospital experience, improving patient safety and reducing readmissions.
Some final thoughts......

- The real key to its continued success lies in......
  ...its appreciation and support by the medical fraternity as a significant and important component of the healthcare delivery system
  ...its recognition as a viable career option for future physicians both in the community and in academia and.....
  ...in its ability to attract the right talent for the right reasons!

- It is time for the rise of the ultimate hyphenated-hospitalist:
  "The Career-Hospitalist"
Thank You.

References:

- **The Emerging Role of “Hospitalists” in the American Health Care System**
  Robert M. Wachter, M.D., and Lee Goldman, M.D.

- **The Hospitalist Movement 5 Years Later**
  Robert M. Wachter, MD and Lee Goldman, MD, MPH
  JAMA, January 23/30, 2002—Vol 287, No. 4

- **The State of Hospital Medicine in 2008**
  Robert M. Wachter, MD

- [www.hospitalmedicine.org](http://www.hospitalmedicine.org)

- [www.Todayshospitalist.com](http://www.Todayshospitalist.com)

- **Best Hospitals**
  US News & World Report 2010-2011

- **Confronting the Hospitalist Workforce Shortage**
  The Phoenix Group, February 2008