

Academic Hospitalists in the Community

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When the hospitalist movement began in the United States, programs differentiated themselves as either academic or community hospital based, but medicine's evolution into an era of high-value care has prompted a convergence of these two groups. In order to remain financially viable, cost effective, and patient centered, some academic medical centers have begun to diversify by developing innovative programs designed around managing population health in an integrated health system model.¹

Historically, academic medical centers attracted a young cadre of energetic teachers who were comfortable in the resident and medical student milieu, having been recently trained in an environment where their role models were inpatient providers. These new faculty began to replace traditional generalist outpatient attendings who would devote a month or two of their time to the wards or sub-specialists who would keep up with their general medicine skills by periodically supervising house staff. In the community, the hospitalist model thrived based on the doctors' accessibility to nursing staff, patients, and their families. Furthermore, administrators promoted the community model, as hospitalists were able to improve throughput and champion newly required quality measures.

The University of California, Los Angeles, has been expanding its primary and secondary care networks within the Southern Californian communities it serves; this expansion, although challenging, has laid the foundation for a successful model of academic and community integration. Over the last several years, the department of internal medicine has

grown its community outreach to include medical and sub-specialty offices and services to the north, south, and west of Los Angeles. In parallel to this health system expansion, our hospitalist section, in the division of general internal medicine, has increased its staff to 85 faculty members working in nine hospitals: three academic and six community based. We currently utilize the integrated group model as defined by the SGIM Academic Hospitalist Task Force.² This system requires that every faculty member be involved with house staff or medical student teaching activities as well as varied clinical responsibilities at a minimum of two facilities encompassing teaching and nonteaching activities. The staffing models within this system have become increasingly complex, and we rely on resilient and diverse faculty to help staff our distant sites.

With UCLA's rapid expansion and growth in regional presence, there was a definite advantage to acquiring existing community groups and appointing them within our hospitalist faculty model; however, this posed a challenge for both sides. Some new hires were not familiar with the academic way and felt less comfortable around residents and students. Similarly, in circumstances where we integrated graduating residents from our urban training program into a community setting, our younger faculty required stronger incentives to relocate and struggled with the mundane, less academic environment of the community.

As our hospitalists integrated into community settings, we discovered solutions to challenges and benefits to this integrative model. One solution was to combine more senior faculty who are settled and invested in

the community with younger early-career hospitalists who are incentivized financially and have a continued interest in academic medicine. The junior faculty members divide their time between the urban academic setting and the community model. A second successful initiative was to recruit a cadre of hospitalist-nephrologists. These highly trained individuals graduated from our fellowship programs and had a strong desire to stay in the region and continue as faculty when they completed training. Fortunately, there is a paucity of urban academic nephrology positions in our market, and we have been successful in creating a niche where these young faculty members are appointed in the department of medicine. They function primarily as hospitalists, develop a relationship in a given community hospital, remain involved in teaching and mentoring nephrology fellows, and slowly grow a referral base in the community setting. Some of these doctors successfully transition to their own outpatient-based hemodialysis practices within a few years or are laterally recruited back into nephrology, whereas others have developed this hybrid model as a career path. We have had similar success with infectious disease-trained physicians, palliative care, and even rheumatology hospitalists. These "double threats" have enabled us to broaden our clinical and teaching scope, provide a more comprehensive level of care, and share salary costs with different divisions.

Another byproduct of our integration is reduction of inpatient costs. At Ronald Reagan Medical Center, our flagship academic hospital and quaternary medical center, it

continued on page 2

SIGN OF THE TIMES

continued from page 1

is far more expensive to provide post-surgical care for a patient after a resource-intensive procedure, such as a liver transplant, than it is at a community hospital. Many of these patients require prolonged inpatient care for hemodialysis, aggressive rehabilitation, and postoperative recovery monitoring. In an integrated model, care can easily be transitioned from faculty at the quaternary center to those in the community setting closer to the patient's home. Furthermore, it allows for the integration of technology, like telemedicine and team-developed care protocols, to improve the quality of care in the community. UCLA is actively exploring such cost-saving initiatives in which our community faculty partner with their colleagues in the academic medical center to keep post-transplant patients in a more sustainable setting while monitoring anti-rejection status, progress of recovery, and resolution of deconditioning.

These initiatives lead to lower-price and higher-value care than can be achieved in the academic medical center and improve the overall care delivered to our patients.

Integrated health systems and population-based health management are crucial for the future success of academic medical centers. Institutions accustomed to conducting research, identifying new treatment strategies, providing tertiary and quaternary care, serving as referral centers for community hospitals, and training future physicians must now begin to evolve. Academia is facing a future concerned with reducing costs and finding ways to be more productive while still remaining true to the academic mission. Traditional revenue streams from grant funding are becoming scarce, and while philanthropy is now playing an ever-increasing role in filling this void, clinical revenue is by far the most reliable source of income for academic centers, especially when favorable contracts can be negotiated

with third-party payers. Integrating academic centers with community hospitals allows academia to benefit from the throughput, infrastructure, and quality measures championed in the community. Community hospitals benefit from the ease of tertiary referral services as well as the higher-caliber staffing provided by the academic health care system. Increased experience in this model of care is an investment that is worth making.

References

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