Hospitalist Medicine

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Revolutions in the Medical System

- Advent of Medicare and Medicaid
- Prospective payment
- Quality and accountability
- Hospitalist medicine

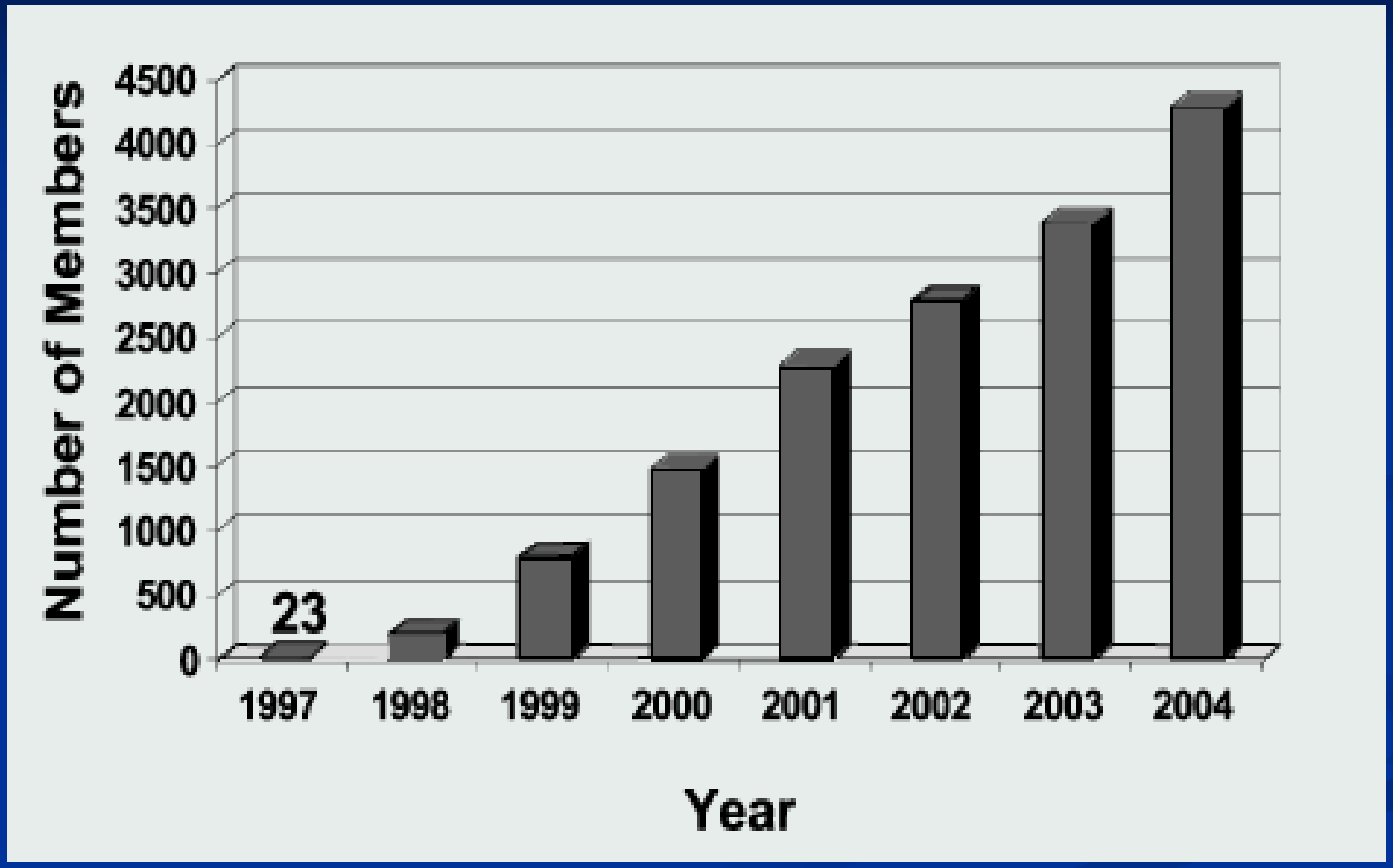
Why did it start ?

- Natural outgrowth of prospective payment and pay for performance. Hospitals needed more control.
- Popular demand. Community physicians didn't want to come in at night. Busy office practices not compatible with sick inpatients for small or moderate size groups. Resident-based teams capped.

Studies of Hospitalists

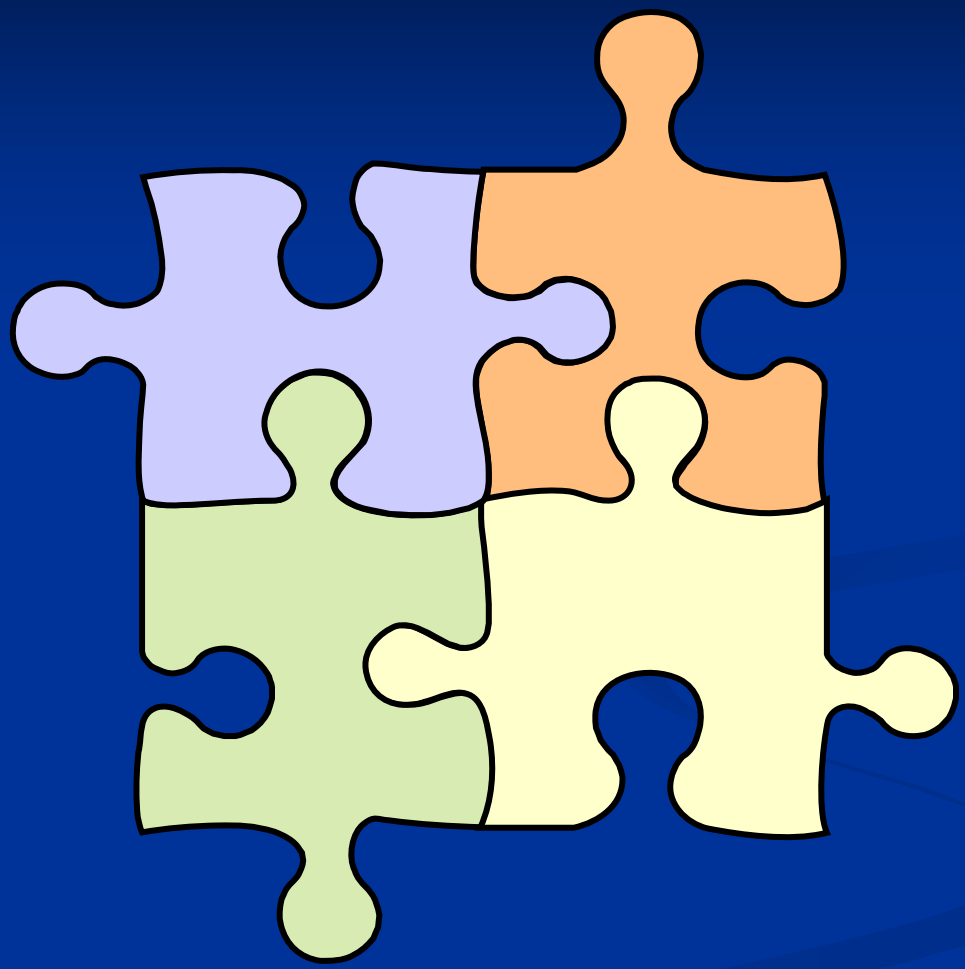
- Often not blinded
- Often not randomized
- Really asks the question:
  - Are hospitalists 'better' or 'worse'? Than what?
  - Should there be hospitalists?

Membership in the Society for Hospital Medicine



Chair Perspective

- Hospitalist medicine is here to stay
- Most are internists
- Issues:
  - Training/teaching
  - Faculty development/retention
  - Economics
  - Research



Where do Hospitalists 'fit'?

- Hospitalists are primary care physicians
  - Generalists by training
  - Cover range of specialties
- Hospitalists are specialists
  - No focus on primary prevention
  - No continuity
  - Proceduralists, inpatient specialists
- Not all hospitalists are internists

Department of Hospitalists Medicine

- Advantages
  - Coordination of inpatient needs
  - Economics clearly defined
  - Faculty could be exclusively hospitalists
  - Incorporate multiple disciplines
- Disadvantages
  - Faculty isolated from others in their disciplines
  - Cross-cultural differences among specialties
  - Training programs may be more problematic
  - Probably not enough specialists are hospitalists yet. Those who focus on inpatient consultation are unlikely to leave their current Depts/Divisions

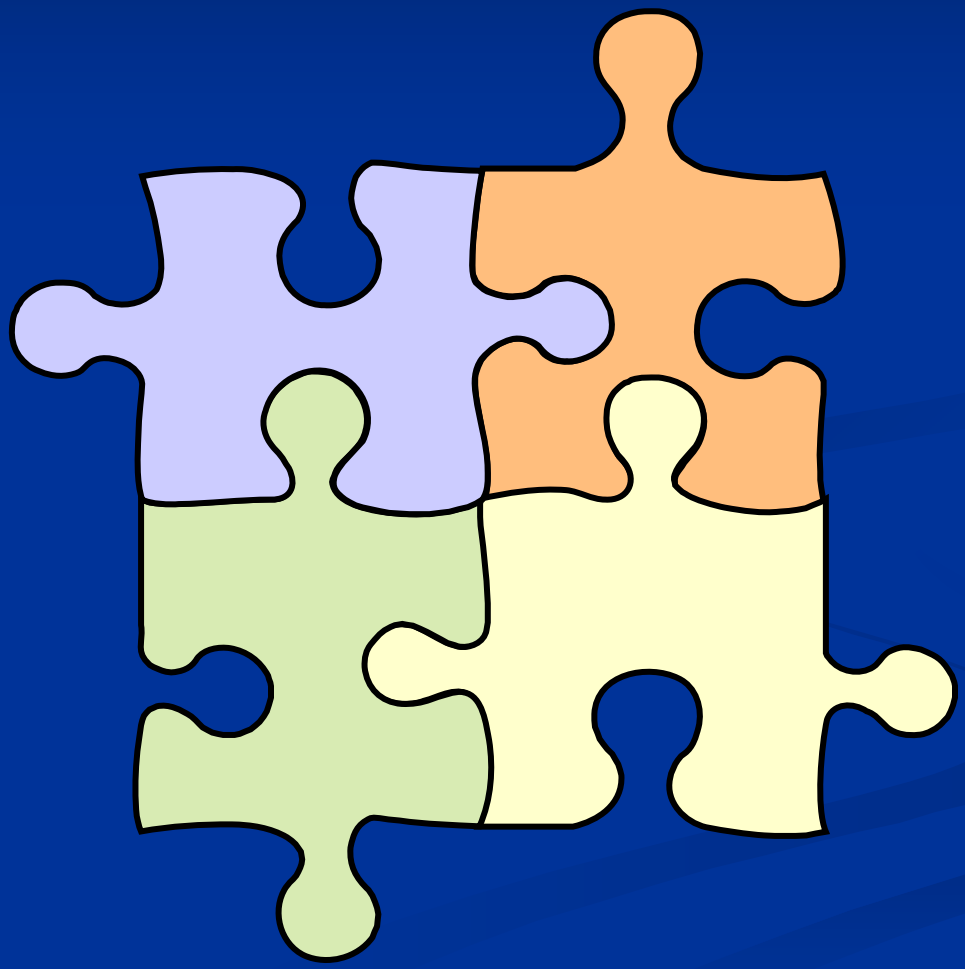
Separate Division of Hospitalist Medicine

- Advantages
  - Inpatient specialists interact closely with each other
  - Economic model not diluted with outpatient medicine or (possibly) teaching
  - Prestige? Research? Easier for hospitals?
- Disadvantages
  - GIM would likely not give up inpatient medicine leaving 2 Divisions doing essentially the same job.
  - Fails to take advantage of opportunities for cross coverage, joint teaching
  - GIM may be pushed into high-overhead settings. Salaries may fall.

Hospitalists in GIM Division

- Advantages
  - Teaching and economic model intact. Reduces competition
  - Ability to share coverage in teaching and service, reduce burden if one hospitalist leaves
  - Broader research setting
- Disadvantages
  - Hospitalist identity may blur
  - Easy to drift into status quo, fail to make important changes

What is the answer?



We are not asking enough questions!

- Not just:
  - Where can hospitalists fit in our system?
- But:
  - How should our system change to accommodate hospitalists?

Where should hospitalist 'fit'?

- Division of General Medicine IF the system can adapt to the needs of the hospitalist
  - Higher salary for increased clinical work, longer hours
  - Change promotion guidelines as needed
  - Mentorship from senior hospitalists
  - Changes in existing faculty clinical practice
  - Willingness to admit current model is not the best model
  - Willingness to change resident education model

Salary

- Inpatient setting has little overhead
- Hospitalists probably devote more total time to the clinical setting, which is where the money is generated
- Hospitalists make more than generalists (MGMA)
- Under most models, hospitalists should earn more than traditional generalists in GIM

Academic Promotion

- Usually pays little attention to clinical accomplishments
- Hospital committee work or quality improvement activities also not sufficient
- Teaching is difficult to quantify
- Guidelines need to change.
- Opportunities for research

  need to improve

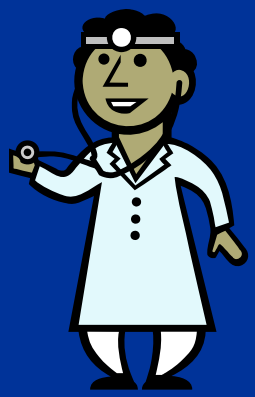
Changing Practice

- Existing faculty
  - May have to cross cover nights and weekends in rotation
  - May have to bring their skill level to that of the hospitalists in some areas
  - May have to spend more time in clinic and less in inpatient settings
  - May have to meet productivity guidelines that are driven by hospitalist-type productivity

Opportunities !!

- Inspire medical students and residents to enter Internal Medicine
- Added economic opportunity beyond the traditional teaching service
- Opportunity for hospital leadership
- Research/Scholarship: How do we make hospitalist medicine a viable career across the physician lifespan? How should we teach hospitalists? How do hospitalist faculty get promoted? Communication between inpatient and outpatient? Tests that come back after discharge?

I want to be in the GIM Division because….



- If we split off, I would have to cover lots more nights and weekends
- My research program is embedded in GIM
- I enjoy teaching. I have inspired IM residents. I think we are a leader in hospitalist training.
- I make just as much money here as I would in a separate Division
- GIM respects me. I get opportunities for faculty development. They nominate me for awards. They help me get grants/organize conferences.
- I am on track for promotion.
- Through my Division, hospitalist medicine has a strong voice in the Dept/College

Where will it end up?

- Subspecialty of Internal Medicine
- Distinct specialty like ER medicine
- Will IM residencies no longer train in inpatient settings and instead outsource this to hospitalists?