Hospitalists as Hospital Leaders

Andrew S. Dunn*

Key Pearls

- Hospitalist leadership in quality improvement and patient safety was spurred on by the Institute of Medicine report, “To Err is Human: Building A Safer Health System,” which estimated that 44,000–98,000 patients die each year in US hospitals due to medical errors.
- The co-management model shows promise as a means of enhancing the quality of care for patients with conditions normally cared for by subspecialists.
- The recognition that hospitals are prone to error and harm has made it increasingly important for physicians-in-training to become knowledgeable in quality improvement methods. Hospitalists will need to be involved in leading innovative efforts to incorporate new material in residency training.
- Hospitalist leaders need to understand the risk of burnout and address this issue directly by paying close attention to work hours and schedules, allowing flexibility and hospitalist input in their schedule wherever possible, promoting engagement and ownership of group policies and performance, and fostering participation in the quality improvement and other activities that many hospitalists find stimulating.

* Mount Sinai School of Medicine, New York, NY, USA.
New models of delivery of care and reimbursement, such as value-based purchasing and Accountable Care Organizations, will require leadership of hospitalists to ensure these initiatives are implemented in a manner which both enhances efficiency and patient care.

Introduction
The revolution is over and the evolutionary process has begun. Hospitalists are now at the center of clinical care for inpatients and the movement to enhance hospital quality and patient safety. This book has been developed in recognition of the motivation of hospitalists to become masters of their craft and be able to improve hospital processes and systems. The primary goal is to provide a practical, easily accessible reference to help busy clinicians deliver outstanding patient care. Additional sections address other vital aspects of the hospitalist role, including principles of hospital quality and patient safety, the essential elements of the business of medicine, pearls for teaching in the hospital setting, and the hospitalist as a researcher.

The Path to Leadership
The field of hospital medicine began modestly after recognition that many physicians were devoting most of their time to inpatient work. A major advantage was quickly noted in the ability to provide a continuous presence for hospitalized patients and for hospital administrators to have a core group providing inpatient care. Primary care physicians also noted the benefits of the efficiency of focusing on their outpatient practice. The momentum grew as many hospitals found they needed inpatient clinicians to help them meet the increasing demands of implementing process improvement initiatives and at teaching institutions to meet compliance with new work duty hour limitations for housestaff. Researchers have since demonstrated the advantages, primarily consisting of decreased length of stay and cost and improvement in some quality measures.1,2

The next step in the evolution of hospital medicine has been to focus on efforts to enhance hospital quality and decrease medical errors. The
emphasis on quality and patient safety was markedly spurred on by the 1999 Institute of Medicine report, “To Err is Human: Building A Safer Health System,” which estimated that 44,000–98,000 patients die each year in US hospitals due to medical errors. The maturing hospitalist movement and the abrupt public recognition of the need to address the quality of care in our hospitals had intersected. As many in the medical field took note of the call to arms, hospitalists were already primed to seize opportunities and lead change.

Over the past decade hospitalists have become local and national leaders in numerous initiatives. Advances include the development of new models of care (e.g. surgical co-management); initiatives in patient safety (e.g. decreasing risk of catheter-related bloodstream infections); enhanced hospital quality (e.g. improved glycemic control); and efforts to enhance efficiency and communication (e.g. transitions of care). Though work in each of these areas is far from over, the accomplishments and lessons learned are invaluable as clinicians look to implement best practices at their local sites.

Leading in Care Delivery

The advantages of the hospitalist model have led to extraordinary growth in hospitalist programs and hospitalists. It has been estimated that there were 30,000 hospitalists in the United States as of 2010, up from 5,000 in 2002 and from 1,000 in the mid-1990s when Wachter and Goldman first described the movement and coined the term “hospitalist.” The rate of growth has been extraordinary and has resulted in hospitalists providing direct care to many patients who would have normally been seen by a primary care provider or a subspecialist. This includes patients beyond the scope of traditional “general medicine” practice, such as patients with acute stroke, acute myocardial infarction, critical illness, and patients at the end of life receiving palliative care. The breadth and the acuity of these conditions challenge hospitalists to master many aspects of medicine. Clearly a “jack of all trades, master of none” approach is inadequate in the hospital setting.
Hospitalists have also been involved in developing new systems of care delivery. Specifically, the co-management model (Chapter 84) has shown promise as a means of enhancing the quality of care for patients with conditions normally cared for by subspecialists. One area where this model has become prominent is in orthopedic surgery. Patients with hip fracture and total hip replacement are typically older and have multiple comorbidities, and assigning a hospitalist attending as the primary physician or as co-attending in a co-management model can allow for comorbid conditions to be fully addressed and care to be coordinated while the specialist focuses on the surgical issue.

**Leading in Hospital Quality and Patient Safety**

Change is difficult in large organizations, and can be particularly challenging within hospitals. Hospitals are inherently complex systems with multiple stakeholders, various agendas, and competing goals. In addition, each hospital has a cultural norm that has developed over many years. “That’s just the way we do it” is a common reason why inadequate processes are not addressed. Hospitalists are uniquely positioned within hospitals to identify errors and vulnerable processes where the risk for future error is high. This opportunity has allowed many hospitalists to lead and implement change (Chapters 6–7). Leadership efforts may also be formalized in key roles for the institution, such as membership on the Pharmaceutical and Therapeutics Committee, Chief Medical Officer, and Director of Quality for a section, division, or department.

Leadership in quality and safety also extends beyond individual hospital walls to the national arena. The Society of Hospital Medicine (SHM) is the field’s main specialty organization in the US, and has grown dramatically in size and influence. SHM has been involved in the development of tools to address crucial hospital processes and outcomes, including medication reconciliation, care transitions, prevention of complications, and reduced readmissions. In addition, hospitalist advocacy helps influence policy decisions at the governmental level on a regional or national stage.
Leading in Education

Many hospitalists now have a major presence on teaching wards, and have direct exposure to medical students, housestaff, and fellows (Chapters 16–17). Teaching skill has taken on greater importance given the movement of medical education away from a memorization model towards developing clinicians who can integrate and incorporate large amounts of data into an appropriate assessment and plan of care. Developing skills in “systems-based learning” has been increasingly emphasized, as the ability to navigate hospital, governmental, and commercial aspects of the healthcare system has become essential. Also, it has become increasingly important for physicians in training to be knowledgeable in quality improvement terminology and techniques. The recognition that hospitals are prone to error and harm and that careful physician oversight can help ameliorate many of these issues has led to greater recognition of the need for training in the relevant skills. However, traditional medical education has ignored this aspect of hospital care. It is now important for hospitalists to become expert teachers as they develop the next generations of hospitalists who will advance current gains and address future problems.

Challenges

The benefits achieved through broad implementation of hospitalist programs have come with recognition of inherent difficulties with the model. Most notably, replacement of the outpatient primary care provider with a hospitalist during hospitalization inserts a minimum of two handoff points. Given that the hospitalist model is responsible for a portion of the discontinuity that plagues a fragmented system, it becomes incumbent on hospitalists to address and overcome these hazardous transition periods. Though much work has been done in this area, the gap persists and needs to be closed.

A second challenge faced by the hospitalist movement is the lack of formal training on clinical topics that are not emphasized in traditional internal medicine residencies, such as hip fracture and stroke, and non-clinical
topics, including quality improvement and the business of medicine. Many hospitalists are eager to work in these areas and train future hospitalists on these topics, but most are unprepared based on being products of the current model of medical education. Hospitalists can address these deficiencies by pursuing additional training (e.g. Six Sigma certification or Masters courses); attending CME (e.g. SHM’s annual meeting); learning by doing (i.e. the “see one, do one, teach one” model); using web-based materials (e.g. the Institute for Healthcare Improvement’s open school); and reviewing easily digested texts (e.g. this textbook).

Another concern is that the intensity of patient care will lead to hospitalist burnout, poor retention, and high turnover at hospitals. A study of 266 academic hospitalists found that 67% experienced high levels of stress and 23% reported some degree of burnout.5 Factors associated with burnout include lack of control of their work schedule and low satisfaction with the amount of time at home or with family. This issue is particularly important given the data showing that many of the benefits of a hospitalist model are seen in the 2nd year of practice and beyond, indicating the importance of retention in any successful hospitalist service.6,7 Hospitalist services need to address this issue directly by paying close attention to work hours and schedules, allowing flexibility and hospitalist input in their schedule wherever possible, promoting a sense of ownership in group policies and performance, and fostering participation in the quality improvement and other activities that hospitalists find stimulating.

The Future

Several factors continue to spur on the growth of hospitalist programs, many of which are likely to become more prominent over time. These include:

- Financial pressure on primary care practices to maximize the number of patients seen in the outpatient setting.
- Increasing acuity and complexity of hospitalized patients.
- The need for expertise in the navigation of healthcare systems to provide timely dispositions for patients.
Hospitalists as Hospital Leaders

- The need to maximize subspecialists’ focus on their field by having hospitalists coordinate care for complex patients.
- Introduction of electronic medical records within hospitals, which will likely encourage some physicians who infrequently admit patients to refer their patients to hospitalist services rather than learn new systems.
- Governmental and commercial initiatives to reduce or eliminate payment for preventable complications.
- Public reporting of quality indicators.
- Emphasis on patient satisfaction, which is likely to be linked to hospital reimbursement.

In addition to continued expansion of clinical care, it is likely that hospitalists will become increasingly vital to efforts to reduce healthcare costs and increase standardization for hospitalized patients. In the US and for many nations, costs are spiraling out of control and the delivery of safe and effective care remains inconsistent across hospitals and regions. Relying on disparate clinicians whose primary clinical focus is in the outpatient arena to systematically address issues related to resource utilization or the structured application of evidence-based recommendations for hospitalized patients is unrealistic. For these issues to be remedied, hospitalists will need to take an even greater role in the delivery of care and its coordination with physicians in ambulatory settings.

Healthcare reform initiatives in the US will spur hospitals to provide higher quality care in a more efficient manner. These include incentives for previously independent entities to collaborate, such as through formation of Accountable Care Organizations (ACOs), in order take a broader view of patient care to achieve overall cost savings. Also, value-based purchasing (VBP) is a model where the traditional fee-for-service system based on the quantity of care is replaced with payment based largely on the quality of care. A VBP formula reduces compensation for hospitals with lower quality scores and provides enhanced compensation for those performing at a high level. Though these sweeping initiatives have the potential to shift the cost curve, patient care may suffer if implemented locally without the input and leadership of hospitalists. For example, an
initiative to deliver antibiotics promptly to all patients with pneumonia to increase a hospital’s VBP score may result in overuse of antibiotics in patients without infection if not designed in a thoughtful manner.

Rigorous analyses of different management options that include assessment of the benefits, harms, and costs, termed comparative effectiveness research, has become a vital tool to inform clinicians, patients, payors, and policy makers on the relative benefits of various interventions. Hospitalists will need to become increasingly involved in these real-world investigations to identify those interventions that are indicated for specific groups, those which should not be implemented due to the harms, and those unlikely to be cost-effective. Many hospitalists are prepared to design, implement, and participate in these crucial studies.

The hospitalist movement will continue to grow and be spurred on by increasing regulatory and financial pressures on physician practices, hospitals, and healthcare systems. Whether these changes result in better outcomes, more uniform implementation of best practices, and more cost-effective care will be up to today’s hospitalists.

References

Hospitalists as Hospital Leaders
