

<b>Report E:</b>	<b>Hospitalists and the Changing Hospital Environment</b>
<b>OMSS Action:</b>	<b>Adopted amended Governing Council Report E, with a change in title.</b>
<b>HOD Action:</b>	<b>Adopted Resolution 731 as amended.</b>

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### **Introduction**

At the 2006 Annual Meeting, the American Medical Association Organized Medical Staff Section (AMA-OMSS) adopted Resolution 7 which called for the following: 1) a study on hospital medicine, 2) solicitation of feedback from hospitalists regarding the services and educational programs that might encourage them to participate in the OMSS, and 3) a study on the effects of relinquishing hospital medical staff membership by primary care physicians on their quality review, peer review, educational opportunities, and interest in remaining active in the OMSS section.

This report provides an environmental assessment of hospitalism, presents research findings from the AMA-OMSS Hospitalists Survey, and offers recommendations.

### **Discussion**

#### **ENVIRONMENTAL ASSESSMENT**

Often called “inpatient physicians” or “admitting officers”, hospitalists spend between 25% and 100% of their time in a hospital setting, serving as the physician of record after accepting patients from a primary care physician (PCP) and then returning patients to the care of the PCP at the time of discharge. A youthful, diverse profession, hospitalism is generally viewed as a product of the managed care industry; it is intended to promote better and more efficient inpatient care.

The hospitalists profession is growing rapidly, and could dramatically change what it means to be an American PCP (some predict that in the coming years, the duties corresponding to inpatient and outpatient care will become as distinct in the U.S. as they now are in Canada and Europe). Questions about the implications of such changes in the U.S. are many: will using “designated hitters” compromise the skill set of primary care physicians? How will hospitalism alter medical education? Will hospitalists need to specialize within themselves? What are the attributes of sustainable programs in hospital medicine?

Many of the nation’s leading hospitals have embraced hospital medicine, including the Cleveland Clinic, the Mayo Clinic, Brigham and Women’s, Beth Israel Deaconess, and the hospitals of the Universities of Chicago, California, Michigan, and Pennsylvania. In addition, the nation’s largest managed care programs are supportive of hospital medicine, including Humana, Kaiser, Aetna, PacificCare, and CIGNA.

Presuming that hospitalists are here to stay, guidance on the design of effective hospitalist programs will be critical to issues of professionalism and patient care across both inpatient and outpatient delivery systems.

### 1.1. What is Hospitalism?

Proto-hospitalist programs, such as the “Rounders” used by the Harvard Community Health Plan, started cropping up around the country in the early 1990s, but the term “hospitalist” was first coined in a 1996 article by Drs. Robert Watcher and Lee Goldman in the *New England Journal of Medicine*<sup>1</sup>. The 5,500 - member Society of Hospital Medicine (SHM) defines hospitalists as “physicians whose primary professional focus is the general medical care of hospitalized patients”.

Hospitalism has grown at a brisk pace in the last decade, both in terms of its scale and in terms of the complexities involved in the job, and the profession has become an important career option for physicians trained in general pediatrics, family practice, and obstetrics. Academic centers are developing residency and fellowship programs in hospital medicine which allow participants to develop experience in all aspects of patient needs during a hospital stay.

A 1998 report by the Council on Medical Service (CMS Report 4-A-98) listed the following potential advantages and disadvantages of the hospitalist movement:

#### ADVANTAGES:

- Improved quality of care and clinical outcomes in the inpatient setting due to the increased expertise and experience of hospitalists, particularly with respect to severely ill patients.
- Improved efficiency and patient satisfaction in the inpatient setting because the hospitalist is available throughout the entire day to see hospitalized patients and to assess potential admissions from the emergency room.
- Improved quality, efficiency, and patient satisfaction in the outpatient setting because the practice of the office-based physician is not interrupted by inpatient rounds and mid-day emergencies with hospitalized patients, and time is not wasted traveling to and from the hospital.
- Enhanced “accountability” and “investment” in the hospital quality improvement process due to the hospitalist being located in the hospital for a considerable portion of each day.
- Enhanced care for indigent patients who were previously admitted as “no doctor” patients.
- Enhanced educational and training opportunities by teaming residents and medical students with experienced hospitalists.

#### DISADVANTAGES:

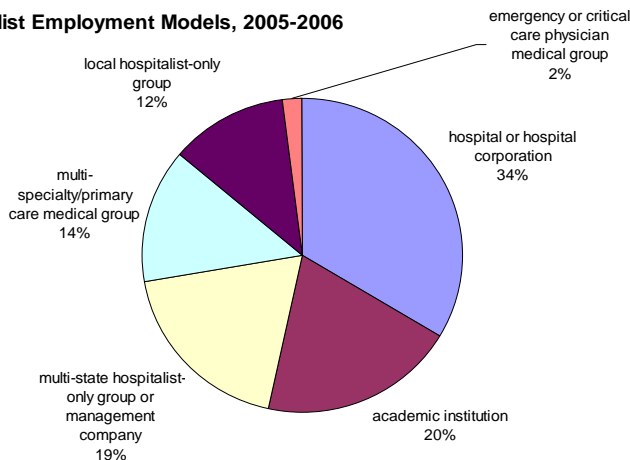
- Compromised quality and continuity of care, and overall loss of communication, when the patient’s physician is unable to treat and follow the patient throughout his or her hospital stay.
- Decreased patient satisfaction by not being able to see “my doctor” in the inpatient setting.

- Increased costs for the overall patient encounter due to a possible duplication of tests and procedures in the outpatient and inpatient settings.
- Erosion of certain hospital-based skills and judgment in the “course of disease,” and decreased physician satisfaction caused by the absence of providing care in the inpatient setting.
- Possible loss of hospital staff privileges and potential difficulty in regaining such privileges.
- Increased likelihood of “burnout” by physicians practicing as hospitalists.

1.2. Data on the Hospitalist Movement

- There are approximately 15,000 hospitalists in the U.S. today<sup>2</sup>, up from 1,500 ten years ago<sup>3</sup>, making the field about the same size as gastroenterology and neurology. SHM predicts that the number of hospitalists in the U.S. could grow to 30,000 by the end of the decade.
- Hospitalism is the most rapidly growing profession in medicine; hospitalists are now present in 70% of U.S. hospitals, where they care for two-thirds of hospitalized patients, on average<sup>4</sup>.
- About 64% of hospitalists are subsidized, with a median subsidy of \$60,000 per year<sup>5</sup>.
- A CIGNA study of its Mid-Atlantic HMO enrollees found that only 25% of hospitalized enrollees were followed by their PCP throughout their hospital stay; the remaining 75% were admitted by emergency room physicians without the knowledge of their PCP or turned over to specialists<sup>6</sup>; this data encouraged CIGNA to support hospital medicine.
- The median age of a hospitalist is 41; their median total compensation package is \$168,000. The median age of hospital medical groups is only four years, the median number of beds at their affiliated hospital is 321; 85% of the affiliated hospitals are non-profit<sup>7</sup>.
- Hospitalists are increasingly important opinion leaders in the social network of a hospital. Approximately 92% of hospitalists serve on committees, 86% participate in quality improvement initiatives, and 51% teach house staff. 35% are responsible for their hospital’s rapid response team<sup>8</sup>.
- There are six models of hospitalists employment<sup>9</sup>:

**Hospitalist Employment Models, 2005-2006**



## RESEARCH FINDINGS

- Patient Care (questions 2.1, 2.3, 2.4, 2.11, 2.12, 2.14, 2.15)
- 1.1. Efficiency (questions 2.2, 2.5, 2.8, 2.10, 3 )
  - 1.2. Network Effects (questions 2.6, 2.7, 2.9, 2.13, 4-7 )
  - 1.3. Implications for AMA-OMSS (questions 18, 20-22)

### **Conclusions**

Due to advances in outpatient care, the typical hospital patient is now sicker and may well benefit from a doctor with more experience in serious illness. However, because high turnover among hospitalists serves to eliminate returns to disease-specific experience, it appears that the greatest weakness in the hospitalist model is the high rate of burnout.

The expectation that hospitalists can perform well while being immersed in suffering and loss day after day cannot be maintained over time. The Organized Medical Staff (OMS) of the hospital should ensure that hospitalist programs are designed in a sustainable way, in order to protect patient care and professionalism. This means hospitalists should have a reasonable case load to be approved by the OMS, should be accountable to the OMS on issues of quality and patient care, and should have protected time for informatics, process improvement initiatives, teaching, and research.

If instead, hospitalists programs continue to be plagued with high burnout, this swiftly growing profession could, over the long term, have dire consequences for inpatients and outpatients alike. It is critical, therefore, that the AMS-OMSS use its influence to encourage sustainability in these critical positions.

### **Recommendations**

#### Recommendation 1:

The Governing Council recommends that the following resolution be submitted to our AMA House of Delegates for consideration at its 2007 Annual Meeting:

RESOLVED, That our American Medical Association (AMA) Policy H-285.964 Admitting Officer and Hospitalist Programs be amended by insertion as follows:

AMA policy states that: (1) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs; (2) participation in "admitting officer" or "hospitalist programs" developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician; (3) hospitalist programs when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff by at least the same notification and voting threshold required to approve a bylaws change to assure that the principles and structure of the autonomous and self-governing medical staff are retained; (4) Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in

"hospitalists programs"; and (5) AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants. (Sub. Res. 714, I-95; Amended by CMS Rep. 4, A-98; Reaffirmed: Res. 819, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02; Reaffirmed: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05) (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the American Hospital Association, The Joint Commission, the Centers for Medicare and Medicaid Services, and the Society for Hospital Medicine to develop model guidelines on sustainable hospitalists programs.

Recommendation 2:

The Governing Council recommends that this report be adopted in lieu of Resolution 7 (A-06).

APPENDIX A

AMA POLICY ON HOSPITALISTS

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**H-225.960 Voluntary Use of Hospitalists and Required Consent**

It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient. (CME Rep. 2, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02; Reaffirmed with change in title: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05)

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**D-225.999 The Emerging Use of Hospitalists: Implications for Medical Education**

(1) Our AMA, through its Council on Medical Education and Council on Medical Service, will collect data on the following areas: (a) the emergence of educational opportunities for hospitalist physicians at the residency level, including the curriculum of hospitalist tracks within residency training programs; (b) the availability and content of continuing medical education opportunities for hospitalist physicians; (c) the policies of hospitals and managed care organizations related to the maintenance of hospital privileges for generalist physicians who do not typically care for inpatients; and (d) the quality and costs of care associated with hospitalist practice.

(2) Our Council on Medical Education and Council on Medical Service will monitor the evolution of hospitalist programs, with the goal of identifying successful models.

(3) Our AMA will encourage dissemination of information about the education implications of the emergence of hospitalism to medical students, resident physicians, and practicing physicians. (CME Rep. 2, A-99)

**D-285.999 Mandatory Use of Hospitalists**

Our AMA will continue its advocacy of Policy H-285.932, in both its private sector and Joint Commission activities by opposing the mandatory use of hospitalists and providing resources and support to physicians facing implementation of mandatory hospitalist policies. (Sub. Res. 714, I-98; Reaffirmed: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05)

**2007 AMA HOSPITALIST SURVEY**

Dear Dr. X:

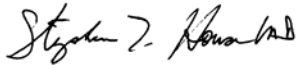
We are asking select physicians, including yourself, to voice their opinion on the growing hospitalist trend through this confidential AMA survey. The survey is sponsored by AMA’s Organized Medical Staff Section (OMSS) in conjunction with the Society for Hospital Medicine (SHM). The survey will close May 15<sup>th</sup>; aggregated results will be made available to the SHM and will be presented at OMSS’s Annual Assembly to be held June 21-23, 2007 in Chicago.

In addition to our many education and advocacy efforts, one of the chief objectives of the OMSS is to involve medical staff members in the development of policies on patient care, professionalism, and self-governance. Our goal is to ensure that the voice of the physician is heard loud and clear in today’s rapidly changing hospital environment.

If you would like to learn more about the OMSS, including numerous opportunities to affect national health care policy, attend free CME courses, and connect with medical staff leaders from around the nation, please visit our website at <http://www.ama-assn.org/go/omss> or contact the OMSS at [omss@ama-assn.org](mailto:omss@ama-assn.org).

Thank you in advance for your thoughtful consideration of the questions below. Together we are stronger.

Best regards,



Stephen T. House, MD, Chair  
AMA Organized Medical Staff Section

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1. Does your hospital have a hospitalists program?
    - a. Yes (continue to question 2)
    - b. No (answer only questions 8-14)

2. Do you agree or disagree that:

	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
2.1 Hospitalists are more effective than PCPs when it comes to delivering acute care					
2.2 Hospitalists are more efficient because they are available in house throughout the day					
2.3 Hospitalists have improved the overall quality of care					

provided in the hospital					
2.4 Hospitalists have improved the quality of care provided by other physicians at the hospital					
2.5 Hospitalists provide a valuable service to primary care physicians					
2.6 The hospitalists model compromises the ability of PCPs to maintain current inpatient skills and clinical competencies					
2.7 Hospitalists are respected members of the medical staff of a hospital					
2.8 Hospitalists are valued by subspecialists and surgeons					
2.9 Hospitalists provide leadership by sharing expertise with other members of the medical staff					
2.10 Hospitals do not spend enough resources on systems supporting PCP-hospitalist communication					
2.11 Hospitalists are effective about communicating patient care information to PCPs at admission and during the patient's stay					
2.12 Hospitalists are effective about communicating patient care information to PCPs at the time of discharge					
2.13 The hospitalists model has decreased the sense of community felt by medical staffs					
2.14 The hospitalists model has negatively affected the physician-patient relationship					
2.15 On average, inpatients are satisfied with the care they have received from hospitalists					

3. Do you think hospitalists workload is too heavy, about right, or too light?
  - a. Too heavy
  - b. About right
  - c. Too light
  - d. Unsure

4. Does your hospital ensure that the use of hospitalists is voluntary?
  - a. Yes
  - b. No
  - c. Not sure
  
5. Some hospitalists are self employed, some are employed by the hospital, some are employed by hospitalists firms, and so on. Would you say that there are important differences in the motivation of hospitalists depending on their employer or are they all about the same?
  - a. There are important differences
  - b. They are all about the same
  - c. Unsure
  
6. Is your hospitalists program formally approved by the organized medical staff?
  - a. Yes
  - b. No
  - c. Unsure
  
7. Do you think that the communication challenges that exist between hospitalists and referring physicians are similar to the communication challenges that exist between specialists and referring physicians?
  - a. Yes, similar challenges
  - b. No, challenges between physicians and hospitalists are less significant
  - c. No, challenges between physicians and hospitalists are more significant
  - d. Unsure
  
8. I am aware of the activities of the AMA's Organized Medical Staff Section
  - a. Yes
  - b. No
  - c. Vaguely
  
9. Gender
  - a. Male
  - b. Female
  
10. Region
  - a. New England (CN, DE, ME, MD, MA, NH, NY, NY, PA, RI, VT)
  - b. Midwest (IL, IN, IA, KS, KY, MI, MN, MO, NE, ND, OH, OK, SD, WI)
  - c. West (AZ, CA, CO, ID, MT, NV, MM, OR, UT, WA, WY)
  - d. South (AL,AR, FL, GA, LA, MI, NC, SC, TN, TX, VA, WV)
  - e. Other (AK, HI, PR)
  
11. How long have you been practicing medicine?
  - a. \_\_\_\_
  
12. How many beds does your hospital have?
  - a. \_\_\_\_
  - b. N/A
  
13. Is your hospital a(n)
  - a. Academic medical center

- b. Teaching hospital
- c. Non-teaching community hospital
- d. Other

14. Does your hospital train PCPs?

- a. Yes
- b. No
- c. N/A

15. Are you a hospitalist?

- a. Yes
- b. No
  - i. Are you on staff at a hospital?
    - 1. yes, with attending privileges
    - 2. yes, without attending privileges
    - 3. no
  - a. Were you once on staff at a hospital?
    - i. Yes
    - ii. No

16. How long have you been a hospitalist?

- a. \_\_\_\_

17. What type of hospitalist are you?

- a. Employed by the hospital
- b. Employed by a local hospitalist group
- c. Employed by a multi-state hospitalist group / management company
- d. Employed by a primary care or multispecialty group
- e. Employed by an emergency group
- f. Academic
- g. Other \_\_\_\_\_

18. One of the primary objectives of the AMA's Organized Medical Staff Section is to educate hospital leaders on best practices in professionalism, patient care, and self-governance. What services and education programs could the AMA-OMSS provide that would be useful to you as a hospitalist?

Services\_\_\_\_\_

Education\_\_\_\_\_

19. Do you refer to hospitalists?

- a. Yes, I refer some of my patients to hospitalists
- b. Yes, I refer all of my inpatients to hospitalists
- c. No, I do not refer any of my inpatients to hospitalists

20. How has your PCP practice changed since attending to fewer inpatients (check all that apply)?

- a. I have more patients
- b. I have fewer patients
- c. I make more money
- d. I make less money
- e. I treat fewer conditions

- f. My skills have diminished in some areas
- g. I have retired
- h. I have changed professions
- i. Other \_\_\_\_\_

21. What impact has relinquishing attending privileges had on your career in terms of quality review, peer review, professional growth and development, and educational opportunities? \_\_\_\_\_

22. One of the primary objectives of the AMA's Organized Medical Staff Section is to educate hospital leaders on best practices in professionalism, patient care, and self-governance. What services and education could OMSS provide to primary care physicians who no longer attend to hospitalized patients?

Services \_\_\_\_\_

Education \_\_\_\_\_

OPTIONAL:

If you would like to learn more about becoming a member of the AMA-OMSS, please provide your contact information below:

Name: \_\_\_\_\_

Email: \_\_\_\_\_

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<sup>1</sup> N Engl J Med 1996; 335:514-7.

<sup>2</sup> Society for Hospital Medicine

<sup>3</sup> *Hospitalists Let Regular Doctors Skip Rounds*, The Wall Street Journal, May 20, 1997, p. B-1.

<sup>4</sup> Andrew Auerback, MD, MPH, UCSF, AMA-OMSS Assembly Meeting Presentation, 11-3-05.

<sup>5</sup> Ibid.

<sup>6</sup> CMS Rep. 4-A-98 p.4.

<sup>7</sup> Society for Hospital Medicine

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.