The Hospitalist Movement: Growth, Value, and Future of Hospital Medicine

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INTRODUCTION

The health care industry is one of the largest and most complex industries in the United States. Within this industry, the hospital industry represents roughly 35% (4.7 million) of employment in the healthcare sector and accounts for over one-third ($718.4 billion) of the United States' health care expenditures (Wallis). Hospitals have been providing necessary care to Americans since 1751 when the first hospital was established, and their importance as a health care institution and as part of the largest industry in the United States continues today. Despite its importance, hospital inpatient care is often criticized for being expensive and inefficient. These criticisms can be partly attributed to the fact that inpatient care has significantly changed in the past fifteen years – inpatient care has transformed into treating a patient population with more complex and more severe diseases and complications, along with an overall U.S. consumer who demands more health care resources (Villanueva, 34). Today, a new model of care is dominating the inpatient setting in what can be seen as a successful effort to meet patient demands of the health care system, control costs, and improve efficiency – the hospitalist model of care. Created in 1996, the hospitalist model of care is centered around separate physicians, referred to as hospitalists, assuming the role of caring for inpatients in place of patients' primary care physicians (Wachter, "Reflection: The Hospitalist Movement", 248). The hospitalist movement plays a crucial role in America's inpatient health care delivery system. Its growth since its inception in 1996 has been tremendous, further demonstrating the importance and value of hospitalists. Specifically, hospitalists' value can be proven through looking at the movement's effect on the hospital system and patient care in five main areas: patient safety and quality, economic efficiency, access

and availability, satisfaction, and leadership and education. Because of hospitalists' valuable impact on inpatient medicine, it is important to ensure that the future of the hospitalist field of medicine will be sustained and continue to grow despite challenges.

HOSPITALISTS: DEFINED, NUMBERS, DEMOGRAPHICS

Hospitalists are physicians "whose primary professional focus is the general medical care of hospitalized patients" (Freed, 239). The term "hospitalist" was coined by Lee Goldman and Robert Watcher in 1996 when they published an article in *The New England Journal of Medicine* that discussed a new model of care in which separate physicians – hospitalists – assumed the role of caring for inpatients in place of patients' primary care physicians (PCPs) (Wachter, "Reflections: The Hospitalist Movement", 248). Goldman and Wachter's vision of the role of hospitalists was for this new field of hospital medicine to improve the value of inpatient care and to "brand hospitalists as indispensable leaders of quality and safety in hospitals" (249). Today, hospitalists are replacing PCPs as the major inpatient providers, allowing primary care physicians to focus on outpatient care completely while hospitalists manage inpatients on-site (Sebgal and Wachter, 591; Leykum and Mortensen, 424). The role of hospitalists has developed to be involved in almost every facet of hospital operations. Clinically, typical responsibilities of hospitalists include patient admissions and daily inpatient rounds, caring for unassigned patients (those without a primary care physician), managing medications, providing emergency department coverage, managing patient and family communication, and working with discharge planning and post-hospital follow-up care. Aside from clinical roles, hospitalists are a unique medical specialty because of the growing organizational role they play in hospital systems and operations. For example,

typical organizational roles of hospitalists include involvement in hospital quality assurance and utilization review activities, teaching of medical students, residents, and fellows, research, and involvement in practice guideline and protocol development (McAlearney, 475). Obviously, hospitalists are more than just inpatient care providers at hospitals. The mix of roles and responsibilities that have evolved as the hospitalist movement has progressed is just one reason why hospitalists are the most rapidly growing group of providers in the United States (Sebgal and Wachter, 591).

Before discussing the evolution and growth of the hospitalist movement, it is important to understand the presence of hospitalists today. Since it's beginning in 1996, the number of hospitalists has grown from a few hundred to almost 31,000 hospitalists (Greeno, 76). It is the most rapidly growing field in medicine and rivals cardiology in size (Sebgal and Wachter, 591). Hospitalist programs are present in nearly 70% of hospitals and are operating in most U.S. teaching hospitals (Greeno, 76). Typically, a hospitalist cares for 12-15 inpatients per day (Kleinpell et al., 9). Since 1996, the odds that an inpatient will receive care from a hospitalist instead of their PCP has grown by almost 30% per year (Leykum and Mortensen, 378). Aside from quantifying the presence of hospitalists in the United States, it is important to understand how hospitalists are trained. Eighty percent of practicing hospitalists are trained in internal medicine. Ten percent of hospitalists are trained in pediatrics, although this number is growing. The remaining 10% of hospitalists are trained in family medicine or subspecialty training fields (Wachter, "The Hospitalist Model of Care"). As documented, the hospitalist movement has grown tremendously since 1996 and has had an impact on inpatient care, especially when compared to the state of hospital care before the movement.

EVOLUTION OF THE HOSPITALIST MOVEMENT: INITIAL INCENTIVES

Before the hospitalist movement, the inpatient model of care consisted of primary care physicians continuing to manage their patients' care while hospitalized. Since primary care physicians had their own outpatient practice to manage during normal business hours, "rounds" to each of their hospitalized patients could only occur early in the morning, during lunch, or at night after business hours (Sebgal and Wachter, 591). This model created a great limitation in inpatients' ability to see their PCP at any time, if needed. Furthermore, PCPs began to find that rounding on their hospitalized patients each day was exhausting, inefficient, and a financial drain (Freed, 240). During this same period between 1970 to the mid-1990s, medicine became progressively complex and specialized, along with a newfound reliance on technology. These factors resulted in accelerated health care costs across the entire sector, but especially increased costs of operating hospitals (Lee, 147). Thus, the need for improved hospital and inpatient care efficiency arose.

The initial incentives for the hospitalist movement were highly influenced by financial demands and the need for hospitals to be more efficient in the way they operated. The root factors of the creation of the hospitalist movement can be identified as a result of pressure from managed care organizations and new government regulations. First, in the 1990s, the domination of managed care organizations in the health care industry revolutionized the paradigm of health care in the United States. Managed care organizations (MCOs) wanted to control health care inflation that was a result of tremendous progress in medicine and technology, and they did so by creating new incentives, such as stricter payment methods, like capitation (Bishop and Kathuroa, 424).

As a result of MCO's new incentives, especially the increased level of acuity justifying hospitalization, treatments and procedures that were once performed in the inpatient setting were now being shifted to the outpatient setting. With an increased patient volume and workload from more inpatient procedures and treatments being performed in the outpatient setting, primary care physicians were becoming overwhelmed. According to Dr. Peter Wallskog, hospitalist and Chief of the Medical Staff at Bloomington Hospital, in order to survive in the managed care market, PCPs were forced to see more patients because "efficiency" was defined as the number of patients seen. Primary care physicians were no longer always able to properly and efficiently round on their hospitalized patients (Wallskog). Secondly, new government regulations, specifically Medicare's reimbursement system, prompted hospitals and physicians to desire a new model of inpatient care. In addition to managed care organization pressures, Medicare implemented a new reimbursement system for hospitals, paying a fixed payment based on each patient's discharge diagnosis, while primary care physicians were still charging per day. Because hospitals were trying to increase efficiency and reduce inpatient length of stay while, at the same time, PCPs were prescribing recovery times that were not financially motivated, hospitals began to search for physicians whose incentives, and clinical skills, were in line with new hospital goals (White, 801). This physician was the hospitalist.

EVOLUTION OF THE HOSPITALIST MOVEMENT: CURRENT INCENTIVES

Today, the incentives for the hospitalist movement are beyond purely financial demands, as they were at the beginning of the hospitalist movement in 1996. After analyzing current health care trends and the effects of the hospitalist movement on

inpatient care, current incentives for the growth of hospitalist movement can be identified as the following: a new focus in health care on quality and safety, restrictions on residency duty-hour limits, trend in co-management, and a national shortage of primary care physicians. First, a new impetus to improve care, especially in terms of quality and safety, in hospitals has led to increased regulatory mandates for patient safety, quality, transparency, and pay-for-performance initiatives. As a result, hospitalists have been called upon by hospital administrators to lead quality and safety improvement efforts. Hospitalists are seen by many hospital administrators as physicians who are familiar with the hospital system and eager to adopt and lead new initiatives. Secondly, restrictions on residency duty-hour limits are another driving force of the hospitalist movement today. Mandated by the Accreditation Council for Graduate Medical Education in 2007, medical residents' workweek was capped at 80 hours, creating the need for hospitals to find alternate providers and systems for inpatient care (Sebgal and Wachter, 592). Teaching hospitals found a solution by creating hospitalist programs, and the duty-hour limits continue to be a main factor in the explosive growth of the hospitalist movement.

The third incentive for current growth in the field of hospital medicine is co-management. With a combination of surgeons becoming busier in the operating room and a limit on resident support from the hour limit, hospitalists have taken on the role of providing consultative and clinical services for surgical inpatients. Hospitalist surgical co-management is becoming increasingly popular in hospitals because of its positive effects on patient care, such as improved quality of care and efficiency (Sebgal and Wachter, 592). Lastly, the fourth impetus of the current hospitalist movement is the result of a national shortage of primary care physicians in the United States. Today, primary

care physicians, who are trained similar to hospitalists in internal medicine and family practice, seek an outpatient only lifestyle. PCPs are in high demand for outpatient coverage plus seek a lifestyle that does not include the specialization needed for inpatient work. Consequently, PCPs have a practice expectation that there will be hospitalists to cover their patients' inpatient needs, which only fuels the demand and growth of the hospitalist movement in the United States.

In addition to the present four main incentives for the hospitalist movement discussed, physicians and hospitals play a crucial role in developing the hospitalist movement into the thriving and valuable field of medicine it is today. In the past decade, physicians have been seeking and establishing new relationships with hospitals (Cors and Rohr, 10). The hospitalist movement is one way physicians have used their clinical expertise and knowledge of the hospital system to build and maintain positive relationships with hospitals. Additionally, much of the growth of the hospitalist movement can be attributed to the fact that physicians who are graduating from medical school prefer to find employment with a hospital or a group contracted to provide services to a hospital (11). Lastly, physicians have been a major driving force of the hospitalist movement because of their desire to deal with challenging and complex cases. Dr. Wallskog notes how graduating medical students are naturally attracted to an environment where there are "medically complicated cases." Hospitals are also contributing to the development of the hospitalist movement because of the appeal of hospitalist programs. In an effort to better align incentives and efforts in providing inpatient care with physicians, hospitals are developing hospitalist programs as a recruiting and retention tool. Hospitals also see hospitalist programs as an attractive

solution for the shortage of emergency department coverage; many physicians do not want to be on-call unless they are compensated (Cors and Rohr, 11). Additionally, because of the importance of needing to meet Centers for Medicare and Medicaid Services (CMS) conditions of participation and accreditation from national entities, hospitals see hospitalist programs as an efficient and useful tool to help with hospital-wide quality and safety initiatives (12). Hospitalists and the formation of hospitalist programs in hospitals provide great value to not only hospitals, but also patients and hospitalists, themselves.

VALUE OF HOSPITALISTS

Much of the literature and research on the hospitalist movement and the impact of hospitalist programs documents the positive impact and value hospitalists add to hospital systems. Specifically, hospitalists' value to the hospital system and patient care can be divided into five main areas: patient safety and quality, economic efficiency, access and availability, satisfaction, and leadership and education. Within each of these areas, the value of hospitalists will be discussed from the point of view of hospitals, patients, and hospitalists. As discussed briefly earlier, hospitalists are positively impacting patient safety and quality. In all of the research on the hospitalist movement, no study has yet to show a decrease in any quality measures. In fact, studies show quality of care has improved from the implementation of hospitalist programs (Cors and Rohr, 10). According to Dr. Wallskog, because hospitalists work routinely in an inpatient setting and are more experienced at taking care of patients, hospitalists have a better ability to look at results and respond to them in a timely fashion. Hospitalists' clinical efficiency is especially apparent when looking at care for the most acutely ill and most clinically

complex patients. One study demonstrates that hospitalists not only improved outcomes for the sickest patients compared to traditional internists' patients, but hospitalists appeared to be most efficient in managing the most acutely ill, which are also the patients that cost hospitals the most money (Davis et al.). This could be due to hospitalists' ability to visit the patient regularly or their ability to effectively coordinate patient care with specialists, both of which contribute to enhanced quality of care and patient safety. Hospitalists also have been shown to improve patient safety and quality through their role of co-managing surgical patients. A recent study examining outcomes of patients undergoing elective hip and knee surgery with surgeon-hospitalist joint care showed that hospitalist co-managed patients compared to patients being cared for by PCPs had faster time to consultation, faster time to surgery, fewer minor complications, and shorter length of stay (Roy et al., 29). Benefits of hospitalist co-management in one study by Sharma et al. showed that patients who were undergoing surgery and who were co-managed by hospitalists experienced fewer transfers to an intensive care unit, fewer postoperative complications, increased likelihood of discharge to home, and a lower six-month readmission rate (363). Clearly, the stakeholder benefits of hospitalists when it comes to patient safety and quality of care are vast. Hospitals experience quality of care improvements, efficiency in follow-up and discharge, and even system improvements from hospitalists' documentation of evidence-based practices. According to Dr. Wallskog, one major benefit to hospitals of hospitalists lies in accreditation. When a hospital needs to be accredited, it is much easier and timely to train a small group of hospitalists versus a much larger group of internists. Patients and families experience improved communication with their provider (hospitalist) and quicker response times for

delivery of test results, both of which affect safety and quality of care. Lastly, hospitalists receive the benefit of being able to become experts in acute inpatient care. Not only do hospitalists add value when it comes to patient safety and quality of care, but they also are improving the economic efficiency of hospitals.

As discussed earlier, the initial growth of the hospitalist movement was due to the improved economic outcomes hospitalists were producing for hospitals. This fact continues today, and much of the literature and research demonstrates hospitalists' potential to improve economic efficiency. First, when compared to patients being treated by a traditional internist or PCP, patients treated by a hospitalist had a shorter length of stay and lower cost of care (Davis et al.). More than 20 studies found that patients managed by hospitalists experienced lower total costs of care, without compromising quality or safety (Sebgal and Wachter, 593). This could be due to hospitalists' ability at better managing complex cases, which are usually cases that require active management and reevaluation. Similarly, a study by Diamond et al. reported that the greatest cost savings for hospitals from the use of hospitalists were associated with the most expensive diagnoses (Davis et al.). Not only do hospitalists reduce length of stay and cost of care, but they also help avoid costs, overall. One study presented at the Society for Hospital Medicine in 2009 found that a hospitalist "care-team" approach to inpatient care yielded especially low readmission rates, particularly for Medicare patients (Greeno, 79). Avoiding readmission of patients, especially those who are uninsured, can save hospitals thousands of dollars. Hospitals mainly benefit from the increased economic efficiency hospitalists provide. As demonstrated, the use of hospitalists has been shown to shorten length of stay, lower overall cost of care, and avoid unnecessary costs due to

readmissions. In addition to the value hospitalists add to the overall economic efficiency of hospital systems, hospitalists also prove to be more accessible and available for patients, especially the uninsured.

It is extremely important for a successful hospital to be accessible and have available doctors to treat patients. The use of hospitalists does exactly this, and hospitals are finding hospitalist programs as an attractive approach to caring for more patients and those who are uninsured. Since hospitalists have been proven to decrease length of stay, hospitals at capacity can see more patients with the use of hospitalists because of the increased access and availability of physicians. Hospitalists' ability to help increase access may allow hospitals to improve their payer mix and possibly offset the financial disadvantages of emergency department cases (Greeno, 79). When it comes to the uninsured, one study evaluating hospitalists demonstrates the value of hospitalists in caring for unassigned and uninsured patients (Kulaga et al., 297). The Society of Hospital Medicine has even stated, "hospitalists have become the inpatient safety net for America's uninsured and indigent medical inpatient population" ("Hospitalists: Leading the Way"). The increased availability and access of hospitalists has been linked to hospitalists' enhanced capability to manage complex patients and, overall, coordinate patient care, when compared to traditional internists and PCPs (Davis et al.). Furthermore, because hospitalists are more available to make multiple rounds in one day versus a patient's primary care physician, patients of hospitalists have earlier recognition and treatment of complications (Kulaga et al., 297). Hospitals and patients clearly benefit from the use of hospitalists, in terms of access and availability. Overall, hospitals benefit from additional clinical coverage, especially in the emergency department. Patients and

families also benefit from the use of hospitalists through possible increased admission to hospitals and, once hospitalized, increased availability of their doctor.

The fourth key area hospitalists play an increasingly important role in when it comes to the hospital inpatient setting is satisfaction, specifically patient and physician satisfaction. First, a review of 19 outcomes documented no reports of patient dissatisfaction with the hospitalist model of care (Freed, 242). Moreover, in a study by Lundberg et al. measuring the effectiveness of hospitalists, it was found that patients cared for by hospitalists had higher satisfaction scores (1313). Higher patient satisfaction for hospitalist patients versus PCP patients could be attributed to the increased availability and communication with hospitalists and a more developed physician-patient relationship while in the hospital setting. Not only are patients benefiting from the hospitalist movement, but hospitalists and other physicians on the medical staff are finding value in the hospitalist model of care, as well. According to Dr. Wallskog, hospitalists are very satisfied professionally. Hospitalists consider their career path to be satisfying because of the mix of clinical and organizational roles. Professionally, hospitalists enjoy geographical flexibility and are not limited to a city by a physician practice, for example. In addition, hospitalists are in the unique position of forming close relationships with hospital staff, administrators, subspecialty colleagues, and even medical residents because of their diverse roles in the hospital (Sebgal and Wachter, 595). Personally, Dr. Wallskog believes a main benefit to the field is that hospitalists can set their own hours versus a PCP or in-office physician who has set hours and possibly additional work, depending on paperwork volume.

Lastly, hospitalists positively impact hospital leadership and educational initiatives and goals. As mentioned, hospitalists are increasingly being called upon to be leaders of quality and safety initiatives. Today, hospitalists are taking on the role of educators in teaching hospitals. Typical educational responsibilities of hospitalists include weekly intern tutorials, medical consultation curriculum, residency mentoring and recruitment, and demonstration of evidence-based practices (Kulaga et al., 295). Since hospitalists are present at most U.S. teaching hospitals, medical students and residents in internal medicine and pediatrics are beginning to receive increasing amounts of their inpatient training from hospitalists (Wachter, "Hospitalists in the United States"). Supporting the use of hospitalists as educators in hospitals, two survey-based studies found that hospitalists were rated significantly higher as educators when compared to traditional attending physicians (Freed, 242). Moreover, studies have found that medical students view hospitalists as having improved teaching and supervision skills (Sebgal and Wachter, 593). In a study by Kulaga et al. examining the impact of hospitalists as educators, hospitalist educators were found to greatly enhance the inpatient experience for medical students and residents. Furthermore, there was a positive increase in resident use of evidence-based medicine and an increased resident awareness of cost. Hospitals, patients, and hospitalists all benefit from the hospitalists' evolving roles of an educator and a leader. First, hospitals get the benefit of having quality and safety leaders, helping hospitals achieve high accreditation standards. Patients benefit from having hospitalists as educators because of the cost-effective, evidence-based medicine hospitalists are teaching to residents and medical students, further improving patient quality of care and safety. Lastly, hospitalists find this role to be extremely valuable and professionally

fulfilling, as they have dedicated time to teach, conduct research, and potentially improve hospital systems of care. Although hospitalists have had, and continue to, a positive influence on inpatient health care and hospital systems, specifically in patient safety and quality, economic efficiency, access and availability, satisfaction, and leadership and education, there are some disadvantages of the hospitalist model.

DISADVANTAGES AND OPPOSITION TO THE HOSPITALIST MOVEMENT

The disadvantages of the hospitalist model can be examined from the point of view of each of the key stakeholders: hospitals, patients and families, and hospitalists. According to Dr. Wallskog, although hospitals may value hospitalists as leaders and drivers of quality and safety initiatives, the hospitalist model of care may result in fewer physicians, overall, to drive these types of programs through. However, the major possible shortcoming of implementing a hospitalist program in hospitals concerns monetary value. In most hospitals, around 15% of patients do not pay and close to 60% pay less than the actual cost of medical care. With the hospitalist model of care, patients who do not pay or those who pay less than cost are spread over only a few doctors. Because of this fact, hospitals are forced to supplement or subsidize hospitalists' salaries (Wallskog). In addition to monetary value, the most cited disadvantage of the hospitalist model of care for patients and families is the unfamiliarity of their inpatient doctor. Dr. Wallskog describes the first encounter with a new inpatient as a "blind date." Additionally, some hospitalist programs have a "7 on, 7 off" rotation where hospitalists work for one week and then take one week off. The disadvantage with this model is if a patient is hospitalized at the end or middle of the week, there is a high possibility the patient might have two different doctors during hospitalization (Wallskog). Lastly,

despite the professional and personal value the hospitalist profession brings to physicians, there are a few potentially unappealing aspects of the hospitalist field of medicine. For example, as the hospitalist movement progresses, there is more discussion on the possibility of burnout for hospitalists. Many hospitalist programs set schedules to avoid burnout, but Dr. Wallskog believes the unchanging hospital atmosphere could cause hospitalists to become professionally uninterested.

As with any new movement or program, there is always going to be opposition to its true value and impact. The hospitalist movement is no exception. Most of the opposition to the hospitalist movement is from a general concern about the negative impact of patient continuity. Research has shown that a lack of familiarity with patients can increase the risk of medical errors of physicians and lead to poor outcomes (McAlearney, 477). Furthermore, opponents of the hospitalist movement believe the discontinuity of care poses an ethical risk from "imposing complete, rather than partial, disruption when patients most need the protection provided by a long-standing relationship" (Kulaga et al.). It is obvious that having a hospitalist treat an inpatient versus that patient's primary care physician disrupts continuity of care, but this disruption is not negative. Hospitalists form important and meaningful relationships with patients and families over the course of hospitalization, in part due to the constant attention, communication, and treatment hospitalists provide (Sebgal and Wachter, 595). As seen from examining the value of hospitalists, quality of care and patient safety actually increases for patients being treated by hospitalists. Along with the negative views of patient continuity of care, resistance towards the hospitalist movement is also fueled by the view that patients will be dissatisfied when cared for by hospitalists versus their PCP.

However, according to multiple literature reviews and research, patients are more satisfied when treated by a doctor who is available at all hours compared to a primary care physician who would only be available during rounds in set, and usually inconvenient, hours. Patients are likely to make a trade off between familiarity of their PCP for the readiness, and often increased efficiency, of a hospitalist. Although opposition to the hospitalist movement exists, the future of the hospitalist movement is likely to be unaffected and will certainly continue to thrive.

FUTURE OF THE HOSPITALIST MOVEMENT

The future of the hospitalist movement has three distinct characteristics – expansion, trend in specialties, and trend in hospitalists becoming leaders of accountable care organizations (ACOs). First, as demonstrated, the roles for hospitalists and the value of hospitalist programs are expanding. According the Cors and Rohr, the overall definition of "hospitalist" is expanding from merely a physician who specializes in inpatient care to a physician who does this, but is also heavily involved in hospital systems improvements, leadership, and medical education (12). New roles for hospitalists include aiding in development of innovative or enhanced clinical services, such as medical consultation and end-of-life care, increasing involvement in medical education curriculum development, and assuming top quality and safety initiatives leadership positions (Sebgal and Wachter, 593). Additionally, with the newfound need for up-to-date health care technology and electronic medical records, hospitalist involvement in the adoption of new health IT systems will further expand the role of hospitalists, since hospitalists are physicians who know the process and realize the nuances of inpatient care delivery. (Sebgal and Wachter, 593). Lastly, the United States' aging population is

certainly expanding the role and need for hospitalists as the health care inpatient delivery system will see an increase in a sicker and more medically complicated patient population (Villanueva, 34). The aging population can also be seen to prompt the trend in hospitalist specialty groups, the second characteristic of the future of the hospitalist movement.

The future of the hospitalist movement can be seen to center around the trend in hospitalist specialty groups. In fact, this trend is already starting, with more traditional inpatient specialties, such as cardiology or neuro-surgery, providing hospitalists (Sebgal and Wachter, 593). As discussed earlier, the aging population is leading to new roles for hospitalists, especially the introduction of hospitalists into specialty roles, such as orthopedic hospitalists and intensivist hospitalists (Kuo and Goodwin, 1653). It is no surprise hospitalists are being involved in these areas because of their documented positive impact on patients with more medical complications. For example, neurohospitalists are becoming increasingly popular in hospitals seeking to become "stroke centers" because of the ability to have a hospital-based neurologist on-hand for complex brain cases. Obstetric hospitalists, or ob-gyn hospitalists, are a growing trend in the hospitalist movement, in part because of the increased patient safety and lower malpractice risk they provide to patients and hospitals (Wachter, "The New Home Team"). Surgical hospitalists are also going to be in demand because of the decreasing reimbursement rate that is causing many surgeons to complete more surgeries per day (Wallskog). The specialty hospitalist can be seen to represent the evolution of the hospitalist idea. In addition, the trend in hospitalists to become leaders in accountable

care organizations can also be seen to represent the progress and growth of the hospitalist movement.

With the passage of the Affordable Care Act, health care reimbursement and care systems are being transformed into higher quality, more efficient systems with strong incentives for coordinated care (Kocher and Sahni, 2579). Because of this, the future of the hospitalist movement will undoubtedly be characterized by a trend in hospitalist leadership in accountable care organizations (ACOs). First, an ACO is a "network" comprised of physicians and hospitals that share responsibility in providing care for Medicare patients, with the aim of increasing health care quality and safety while decreasing costs (Gold). The goal of ACOs is to coordinate care among all players in the patient's health care experience, such as specialists, hospitals, and primary care physicians. Because hospitalists have already demonstrated their ability to implement system improvements within hospitals, coordinate care, and practice evidence-based medicine, hospitalists will become leaders in the value and direction of ACOs. The success of ACOs requires a strong cooperation among participants clinically, administratively, and fiscally – all facets hospitalists work with everyday. However, despite the positive future of hospitalists in the United States, it is necessary to address key challenges in the field in order to propose recommendations for the sustainability of the hospitalist profession.

KEY CHALLENGES

The main challenges confronting the hospitalist movement are communication, funding and economic viability, physician burnout, and workforce shortage. As in any profession, challenges exist, and it is crucial these be discussed and addressed in order for

the hospitalist movement to continue its growth, value, and impact. First, communication "breakdowns" are the main concern of primary care physicians, hospital administrators, and even hospitalists when it comes to challenges of the hospitalist movement. This is because the involvement of multiple physicians – PCP, hospitalist, specialist – can lead to gaps in communication, missed information about patient care, and misunderstandings among the different physicians (McAlearney, 477). According to Dr. Wallskog, the potential for communication gaps between hospitalists and outpatient providers is a risk inherent in the hospitalist model, especially since the technological solution to this problem – electronic medical records – is not available at every health care facility. Specifically, the biggest communication concern of the hospitalist movement is the potential for patient discharge miscommunication. Although patient discharges are the most common methods of communication between hospitalists and PCPs, discharge summaries have the greatest potential to fail to provide necessary information. Studies on the completeness and accurateness of discharge summaries show that discharge summaries often lack necessary medical and administrative information and may not arrive to the outpatient physician in a timely manner (Kripalani et al., 315). Another study found that the patient's discharge summary had not arrived almost 75% of the time when the patient followed up with their PCP for the first time after hospitalization, which resulted in the PCP's inability to provide follow-up 24% of the time (316). Dr. Wallskog believes, in general, discharge summaries inherently will always lack the "flavor and finer points" of medicine and a patient's severity of illness.

A second challenge for the future of the hospitalist movement lies in its funding and economic viability. Currently, the traditional approach to funding hospitalist

programs remains the dominant method, which consists of hospitals structuring programs like a staffing model. Physicians are compensated on productivity, not their ability to improve hospital efficiency, especially quality and safety (Greeno, 77). In addition to a traditional approach to funding a hospitalist program, hospitals are forced to subsidize hospitalist salaries, further increasing the potential economic impediment to implementing a hospitalist program. Since many hospitalist activities, such as leadership and organizational roles, are not reimbursed by the fee-for-service payment system, hospitals must supplement hospitalist pay in order to reward and incentivize hospitalists for coordinating care. As a result, hospitals are often required to justify their funding of hospitalist programs, something that budget cuts and hospital leadership change could negatively effect (Sebgal and Wachter, 594).

Aside from the current challenge of funding a hospitalist program and ensuring it's economic viability, one looming challenge the hospitalist movement is likely to face is physician burnout among hospitalists. Many hospitalist programs work continuous hours throughout the day, every day of the year. Because of this fact, it comes as no surprise that early surveys from the Society of Hospital Medicine suggest current burnout rates of 13% or higher and state that an additional 25% of practicing hospitalists are at risk for burnout (Sebgal and Wachter, 594). Current hospitalist burnout and the potential risk could result from an increasing workload due to the growing number of unassigned patients admitted from hospital emergency departments for inpatient care (Freed, 242). Other factors that could lead to hospitalist burnout include stress, routine days, and even weak institutional support (Wachter, "Hospitalists in the United States"). Lastly, along with hospitalist burnout, another challenge for the future of the hospitalist movement is a

potential workforce shortage. The sustainability of the hospitalist movement has always been a concern among physicians and administrators in the field who have witnessed the movement's rapid growth over the last 15 years. Evidence of the difficulty in sustaining the growth of the movement is already apparent. For example, as mentioned, almost 75% of hospitalists train as general internists, yet in 2007, a survey of medical school graduates revealed that only 5.1% planned to practice internal medicine, showing a declined lack of interest in the field and hospitalist profession (Bishop and Kathuroa, 428). Additionally, a lack of knowledge and training among residents on the rewards and benefits of the hospitalist career and inadequately managed compensation programs that reward inefficiency are other factors contributing to the potential hospitalist workforce shortage (Singer et al., 2). Overall, despite the challenges confronting the hospitalist movement, which include communication gaps, funding and economic viability, physician burnout, and a potential workforce shortage, there are many solutions and recommendations for ensuring the sustainability of the hospitalist profession.

RECOMMENDATIONS FOR SUSTAINABILITY

First, it is extremely important for the communication gap between hospitalists and primary care physicians to be closed, especially concerning patient discharges. As noted earlier, most errors in the hospital setting are a result of "communication breakdowns" between the hospital team and the primary care physician, so it is crucial hospitals find innovative solutions to this problem (Kripalani et al., 315). One solution that will most likely be seen in the future is the use of electronic data and medical records to help enable communication between hospitalists and outpatient providers and also decrease the possibility of a negative impact on continuity of care. When it comes to

improving the lack of necessary information in patient discharge summaries, electronic summaries can ensure an efficient and timely delivery to outpatient providers and even highlight important medical aspects of a patient's discharge summary. Until all hospitals and outpatient providers have access to electronic medical records, simple hospital policies can prevent insufficient patient discharge summaries. Demonstrating its importance, the Joint Commission on Accreditation of Healthcare Organizations set communication as a 2008 patient safety goal, recommending a "standard approach to handoff communications" (Bishop and Kathuroa, 425). For example, hospitals can create a policy for patient discharge summaries that requires key information to be included, such as patient's diagnosis, test results, any medications the patient may be taking, follow-up arrangements, physical and mental state of patient at discharge, and any pending tests or diagnosis at discharge. Hospitals can also create a policy that would require in-person or at least phone communication between hospitalists and PCPs when discharging a patient. This could potentially prevent any miscommunication about a patient's condition and follow-up procedures at the time of discharge.

Second, because hospital funding and the structure of hospitalist programs are chief aspects of a successful hospitalist program, it is essential that hospitals approach their hospitalist program appropriately. As discussed earlier, most hospitals use the traditional approach to funding their hospitalist program, which structures the program like a staffing model. However, the use of a non-traditional approach, which views hospitalists as partners, creates the sense of hospitalist programs being an investment versus an expense (Greeno, 77). Hospitalist programs need to begin rewarding hospitalists for efficiency and increases in patient safety and quality instead of

productivity and patient volume. The non-traditional funding approach does this and aligns hospitalists and administrators. Also, hospital employment of hospitalists might lead to less fragmentation and encourage a "team approach" to organizational and clinical problems.

Thirdly, with hospitalists likely to become leaders of accountable care organizations in the future, it is necessary for hospitals to adequately provide training. For example, a successful hospitalist program might include leadership training and management skills to teach hospitalists how to effectively manage teams and motivate others. Additionally, since electronic medical records and technology are on the rise, hospitals should provide hospitalist training in information technology. Lastly, because of the strong emphasis on increasing safety and quality in the hospital setting, hospitalist programs should focus on providing education about improving systems of care and using evidence-based medicine practices.

Finally, it is essential for hospitals and hospitalist programs to find ways to avoid burnout and increase attraction to the field of hospital medicine in order to prevent a looming workforce shortage. First, the evolving mix of clinical and non-clinical roles hospitalists are taking on is one way to increase job satisfaction and sustainability. Specifically, non-clinical roles, such as roles in quality improvement, leadership activities, and education, will help prevent hospitalist burnout. In an effort to increase attraction to medical students and residents of joining the hospitalist field of medicine, hospitals and hospitalists need to publicize the advantages of the field, such as a variety of clinical and organizational responsibilities, favorable schedules, and education leadership. Overall, these recommendations target the key areas the hospitalist movement

needs to focus on in order for ensured sustainability of the profession and continued growth and value of the field.

CONCLUSION

In conclusion, the growth and value of the hospitalist field of medicine in the last 15 years has revolutionized the way inpatient care is delivered in the United States. With hospitals being one of the largest sectors in the health care industry and accounting for over one-third of total U.S. health care expenditures, it comes as no surprise that the need for hospitalists in the inpatient delivery system continues today, just as it did in the late 1990s. Although the incentives for the hospitalist movement have changed from purely financial to an increased focus on leadership, patient safety, and overall health care quality, the value and impact of hospitalists on clinical care, as well as hospital systems, has remained the same and continues to be more widespread. Hospitalists positively impact all facets of inpatient care and hospital systems, adding the most value to patient safety and quality, economic efficiency, access and availability, satisfaction, and leadership and education. Despite little opposition to the movement and challenges when it comes to communication, funding, physician burnout, and a possibility of a workforce shortage, the future of the hospitalist movement and profession remains strong. Peter Drucker, a renowned philosopher and writer once said American hospitals are "the most complex…organizations ever devised." This statement, coupled with the fact that inpatient care is growing in demand and severity of disease, signifies the need for hospitalists to stay in the American inpatient delivery system and continue to make meaningful strides in inpatient care and, overall, the U.S. health care system.

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