## Key Issues for Academic Hospitalist Programs

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### Six Major Issues

- Funding the program (and demonstrating value)
- Working with surgeons
- Non-teaching services
- Divisions of Hospital Medicine
- Research
- If time: Training programs for hospitalists

### How Much Hospital Support?

1. Define a “clinical FTE”
2. Figure out how much it brings in (in usable $s)
3. Figure out how much it costs for a quality academic hospitalist (fully loaded)
4. Calculate the difference
5. How many of these “FTEs” are needed
6. $4 \times 5 = \text{the needed support (from someone)}$
UCSF Case for Support

1. Define a “clinical FTE”: 10 wards mths/yr
2. Figure out how much it brings in (in usable $s): $12,000/month
3. Figure out how much it costs for a quality academic hospitalist (fully loaded): ~$200,000
4. Calculate the difference: $80,000/FTE
5. How many of these “FTEs” are needed: About 9
6. 4x5 = the needed support (from someone): Approximately $700,000/year

Support Pearls

- Figure out who benefits
  - Don’t mix apples and oranges (med center won’t pay for research, DOM won’t pay for efficiency)
- Demonstrate the ROI, but don’t hitch your financial star to it
- Need demonstrable #s in early years (measurable value), but over time it gets more personal
- Need somebody to lead and broker all of this
  - “Oh, I just had an idea. The hospitalists can help…”

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“In the Full Hospital, the Surgeon is King”

Or, in the immortal words of UCSF’s Chief Medical Officer…

“Bob, a medical patient is slightly better than an empty bed.”

UHC LOS Index for Four Major UCSF Services
Additional Potential Surgery Cases/Year Made Available by Saved Bed-Days on Medicine

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*Approx. yearly admits

The Surgeons

- Biggest issue of them all viz volume
- Can be biggest advocates
- But high reward/high risk
  - Liability concerns
  - Dumping ground concerns
  - Money concerns (aren’t they getting a “global fee”?)
- Proceed cautiously, but welcome their interest

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Non-Resident Hospitalist Services

- The Need
- Issues to consider during development
- The U of M and UCSF experience
- Challenges

Residency Work Hours

- Non-teaching services
  - Reduced hours requires reduced patient load
  - No dollars for more residents
  - Non-housestaff hospitalist services
  - 11 of US News and World Report top 15 hospitals have created (or are developing) these services

Non-Resident Service: Program Goals

- The NEED....
  - Response to increasing admissions
  - No increase in number of residents
  - ACGME work hours restrictions: exceeded

- A solution...
  - Create a non-resident faculty hospitalist service
  - Shift admissions from resident services
  - Compliance with work hours
  - Wide variety of patients moved to single service
    » Safe, effective, and efficient care
    » Allows for a focus on institutional QI
### U of M’s Medicine Faculty Hospitalist (MFH) Service

- 24/7, no need for resident coverage
- Patients from all services
  - 4 Gen Med Services
  - Newburgh
  - Heme / Onc
  - Pulmonary
  - GI / Liver
  - Cardiology
- Estimated 4000 +/- admits / year
- Census up to 70

### Building a Non-Resident Service

#### What Volume of Patients?
- Determine housestaff volume (avg. census / intern)
- Add other patients (hospital growth, specialty?)
- “Uneducational patients” vs. All-comers
- Account for patient contacts per day (vs MD census)

#### Funding
- Do you want to do this, or does someone else want it?
- Factor in clinical revenue “pulled away” from faculty on resident services
- How hard will it be to hire hospitalists in your area?
- Don’t forget “infrastructure costs”
- What about dept profit! I kid you not.

### Building a Non-Resident Service

#### How do patients get to this service?
- Do not affect ER flow!
- Understand the institutional peaks and valleys in admission volume
- Admitting all night and covering a large census probably requires > 1 doc at night: HUGE IMPLICATIONS
- Resident vs. hospitalist triage
- If residents triage……they will “cherry-pick”
- If hospitalists triage……residents will complain

#### Do you need Physician Extenders?
- Depends on the type of patients
Building a Non-Resident Service

- **A hybrid faculty staffing model**
  - Some faculty do only non-resident work
  - Some faculty do no non-resident work
  - Many do both
  - Make the non-resident work more satisfying
    - Ample time off
    - QI efforts
    - Participatory research
    - Student teaching
    - Resident teaching: procedures, noon lectures, etc.
    - Faculty meetings, faculty case conference

Medicine Faculty Hospitalist (MFH) Service

- Estimated need for 8 FTE Hospitalists
- Supplemented by 4 Physician Assistants
- Initial model based on national data for hospitalists
  - Limited data on structure for major academic med centers
  - Census of 40-45 requires 8-10 FTEs
  - National average of 17-18 shifts/doc/month
  - National average of 12-13 patient encounters/doc/day
  - In academic settings, hospitalists working on non-resident services paid 30-50k/yr more
  - Incentive Program: RVUs, QI, Professionalism

The Inefficiencies of Academic Medical Centers

- **Radiology:** “Nothing happens unless you spend hours making it happen…”
- **PICC/Angio:** “No slotted time for PICCs…we had one patient wait 4 days for elective G-J tube replacement…4 days of LOS wasted”
- **Clerks:** “Wide variability in performance…orders not taken off in timely fashion…we have to double-check all the time for safety purposes”
- **Practice Management:** “No back-up for illness, etc. Two days last week our PM was out. The service ground to a halt. At any point in time I have ¼ (4/12 today) of my pts waiting for placement. Unless they move I can take no more.”
The Inefficiencies of Academic Medical Centers

- **Consult services:** “We call at night on a Wednesday and get recs after 5pm on Thursday…”

- **Phone system:** “After I call back a page I wait 2-3 minutes before the nurse is on the line…when I have 30-40 pages / day that adds up”

- **Nursing support:** “some floors draw blood off PICCS, some don’t. I write for stat labs and get called 30 minutes later to come draw them myself.”

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MFH: Additional Roles

**Capitalizing on 24 / 7 availability**

- **“Code Blue”**
  - Attendings now at all codes
  - Quality, safety, teaching

- **Procedures**
  - Attending oversight of after-hours procedures

- **Medical consultation after hours**
  - The 2 am pre-op allowing surgery at 6am
  - Assistance with surgical co-management

- **“24 / 7 throughput”**

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MFH: Year 1

- 1800 admits
- Avg daily census rarely <30
- Mean RVUs / doc = 2800 (3000-2600)
- Resident Hospitalists: Mean RVUs / doc=3700
  - Year prior was about 500 / doc higher
- 4 docs stayed for yr 2; 4 docs left (planned)
- Easily recruited 4 more from our own program
- But…..we doubt this is sustainable
MFH: Year 4 (2007-2008)

- 4300 admits
- 20 FTEs; 6-7 PAs
- Census: 70
- 2 docs on at night: RRT, resident back-up, codes
- Resident services capped! It is now our problem if the hospital gets too busy...like the community.
- New beds opening, new CV center, etc.....projections suggest need for 26 FTEs for non-resident work alone

U of M Hospitalist FTEs

Non-Resident Services: Challenges

- Faculty turnover, recruiting
- Growth: please stop
- The nights
- Institutional “respect”
- Academic promotion: job evolution
- Highly specialized patients
  - Specialty services now in the non-resident business
- Did I mention the nights?
Non-Resident Services: Challenges

◆ Specialty Services:
  – Cards
  – Heme-Onc
  – Others!

◆ Hiring:
  – 1-2 year folks
  – Lifers…

Non-Resident Services: Challenges

Hiring short-termers

◆ Pluses:
  – More work for less pay? Easier to find
  – Extra training for fellowship (esp cards / heme one services)
  – No need to provide “academic opportunities”
  – New faculty bring new perspectives, fresh air, and are not burned out
  – Recent graduates: comfortable with “non-resident” work

Non-Resident Services: Challenges

Hiring short-termers

◆ Minues:
  – Are these really “hospitalists”?*
    » Can they deliver quality / efficiency
  – When you have 30 of these, yearly recruiting / hiring / training is a full-time job
  – Group becomes very “non-academic” overall
  – The Hospitalist Program is just a bunch of 4th year residents
### Six Major Issues

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### Divisions of Hospital Medicine

- How many of these are there?
- Division vs. Section
  - Is the Hospitalist Program Director on the same level as Chief of Endocrinology?
  - Is there an outpatient counterpart?
- Heterogeneity of Institutions
  - Community Hospital: non-teaching
  - Major academic medical center

- There will be a spectrum of organizational structures
- What are existing organizational principles
  - Research / Training
  - Clinical Domain
  - Size / Revenue
- Separate Division
  - No overlap / interaction with rest of GIM division
  - Hospitalists > Non-hospitalists
  - One group less research oriented than the other (or no research); or research occurs in “centers”
  - Separate training programs
Divisions of Hospital Medicine

- Within another division (GIM, Pulm?)
  - Division has strong research / training mission
  - All other divisions emphasize research / teaching
  - Good Inpt / Outpt relationships
    - Share projects
    - Share infrastructure
    - GIM attends some on wards
    - Hospitalists do urgent care?
  - GIM Chief / Hospitalist Lead interact well
- All politics is local

A Few Basic Tenets of Leadership

- Understand and apply basic change principles
- Data rules, mostly…
- Make yourself indispensable, and be willing to test that from time to time
  - a.k.a., prepare for a near-death experience
- Even though it is academia, it’s still real money

The Win-Win
A Few Basic Tenets

- Understand and apply basic change principles
- Data rules, mostly...
- Make yourself indispensable, and be willing to test that from time to time
  - a.k.a., prepare for a near-death experience
- Even though it is academia, it’s still real money

Yet it won’t all be data driven...

Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials

Glebova C, Sankar JFP et al.

Abstract
Objective To determine whether parachutes are effective in preventing injuries related to gravitational challenge.

Accepted interventions were parachute devices secured by means of a harness worn by the participants and released to prevent a catastrophic, non-mortality during flight with the purpose of limiting forces of impact. The study found that both were effective.


A Few Basic Tenets

- Understand and apply basic change principles
- Data rules, mostly...
- Make yourself indispensable, and be willing to test that from time to time
  - a.k.a., prepare for a near-death experience
- Even though is is academia, it’s still real money
Hospitalist model demonstrably working
- Inc. positive ROI, national visibility, etc

**BUT**

- Hospital losing $1M/week
  
**SO**

- “We need to cut your budget by 30%… It’s not that you’re not doing a great job.”

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When Push Comes to Shove…

**Hard Line**

Negotiate?

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Related Principle: Be Willing to Volunteer… For a While

- Sometimes only way to show indispensability
- Set limits on what you can and can’t do for free
- Measure impact -- data (esp. $s) trumps impressions
  - Most of the time
- Be ready to walk…
  - But only in the nicest way
A Few Basic Tenets

- Understand and apply basic change principles
- Data rules, mostly…
- Make yourself indispensable, and be willing to test that from time to time
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- Even though is *is* academia, it’s still real money

A Junior Faculty Member’s Epiphany…

“I get it. We’re all individual entrepreneurs out there trying to sell our ideas…

and UCSF just lets us use that nice letterhead.”

Final Key Principle in Managing an Academic Hospitalist Program

- Principle #1
- Recruit and retain great people
- Principle #2
- There is no principle #2
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Hospital Medicine Research

- Critical to the future success of the field
- A requirement for a “specialty”
- Desperately needed
- Key areas to target include
  - Nosocomial Infections
  - Errors and safety issues
  - Common diseases (CAP, etc.)
  - Translating research into practice
- But how to do it?

Hospital Medicine Research

- Build research expertise
  - Within your group
    - Recruit a “rain-maker”
    - On the job training
    - By partnering with another division (Gen Med?)
- A research infrastructure is needed
- Get the whole group involved
  - A few leaders
  - Lots of participants
  - Goal of at least two “scholarly works” / year
- Reach out to others
  - Subspecialists
  - Other institutions
HELPS Consortium

- Hospitalists as Emerging Leaders in Patient Safety
- A consortium of 9 healthcare institutions in Michigan
  - Academic, Government, Urban, Rural, Teaching, Non-Teaching
  - One hospitalist / One patient safety or QI officer
- Targeting few to affect many
  - 9 hospitalist programs: >80,000 admits / year


HELPS Consortium: Targets

- Device-Related Infections
- Creating a Culture of Safety
- Perioperative Care
- Discontinuities in Inpatient Care
- ICU: Preventing Nosocomial Pneumonia and Improving Antibiotic Utilization
- End of Life Care
- Inpatient Geriatrics: Preventing Falls


HELPS Consortium

- Dissemination of Best Practices
- Presentation of successful and failed implementations
- Research staff to assist with analysis of new interventions; rapid cycle improvement
- Identify predictors of success and failure
- Is the “hospitalist angle” worth pursuing?

U of M: SHARP Program

- Specialist-Hospitalist Allied Research Program
- Pair specialists with hospitalists
- Specialists: content knowledge / credibility
- Hospitalists: systems knowledge / availability
- Targets:
  - Blood culture contaminants (ID)
  - Medication misadventures (Pharm, Geriatrics)
  - Codes: Time to Rescue (Cardiology)

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Hospitalist Training Programs

- What to include in a curriculum
- The UCSF program: Now you see it, now you don’t
- The University of Colorado Program
Training Hospitalists: What to Include in a Curriculum?

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UCSF Hospitalist Residency Track

**Elements of the Track**

- The categorical IM residency program
  - Wards, ICU, CCU, ER, Procedures, Subspecialty-Electives, Ambulatory Block, Continuity Clinic
- Hospital medicine elective
  - 1 month, At the core of the track
- Journal clubs
- Ward work with hospitalists
- ORACLE / TICR; 2 month research course
- Mentored project with faculty, presented at a national meeting

Hauer K, Flanders S. West J Med. 1999

The Elective Month

- Several Modules
  - End-of-Life Care
  - Teaching Hospital Medicine
  - Inpatient Geriatrics
  - Patient Safety
  - Inpatient Outcomes Research
- Communication, med consult, economics, QI
- Site visits; other programs, hospice, SNF
- Hospital medicine project