

The Growing Use and Recruitment of Hospitalists

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions company in the United States.

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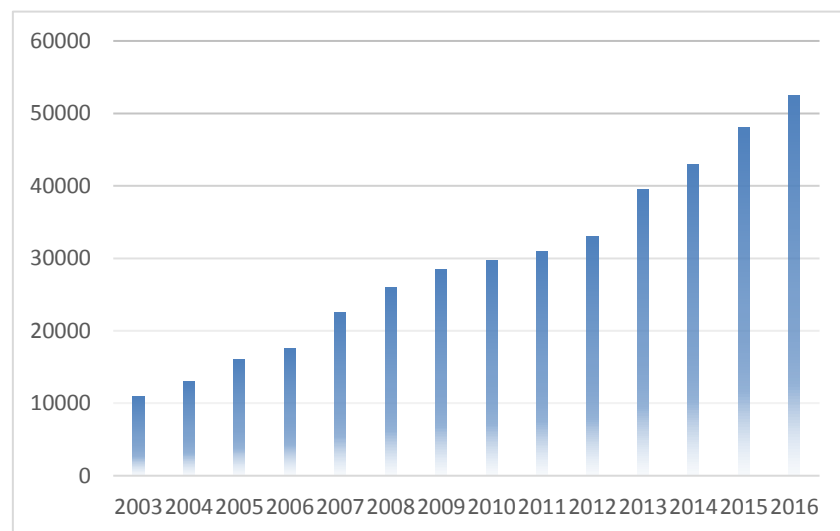
Introduction

“Hospitalist medicine,” still a relatively new area of practice, recently celebrated its 20th anniversary.

It was in 1996 that Robert M. Wachter, M.D. and Lee Goldman, M.D., M.P.H., coined the term “hospitalist” to describe a new class of specialists defined not by the types of maladies or organ systems they treat but by the site of service in which they practice (i.e., the hospital).

Twenty years ago, only a few hundred doctors practiced as hospitalists. By 2003, the first year the American Hospital Association began tracking hospitalists, there were some 10,000. Today, the number of physicians practicing as hospitalists has grown to approximately 52,000. The chart below illustrates the rapid growth in the ranks of hospitalists:

Number of Hospitalists, 2003-2016



Source: *New England Journal of Medicine*. Sept. 15, 2016



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The number of physicians practicing as hospitalists now ranks fourth among all medical specialties trailing only general internal medicine (110,000 physicians), family medicine (107,000) and pediatrics (55,000), (see *The 20th Anniversary of Hospitalists, The New England Journal of Medicine, September 15, 2016*).

Reasons for Growth

The increased use of hospitalists was spurred in part by the introduction of Medicare's diagnosis-related-group (DRG) model of payment, which pays hospitals a fixed sum for various services independent of patient length of stay in the hospital. After DRGs went into effect, hospitals were financially rewarded for reducing length of stay and for the appropriate utilization of resources. This required the presence of in-house physicians who would be available around the clock, rather than office-based physicians who would round once or twice a day to monitor patients and initiate discharges. The trend was further facilitated by the implementation of electronic health records (EHR) which made it possible for physicians meeting patients for the first time in the hospital to access their medical histories.

Studies soon made it apparent that hospitalists could reduce costs, shorten lengths of stays, and in some cases maintain or even enhance quality of care and patient satisfaction.

The ongoing proliferation of value-based payment models encouraging team-based care, resource utilization, the elimination of errors known as "never events," and hospital readmissions have further driven the growth of hospitalists. Hospitalists are particularly attuned to emerging models of care because they have long worked in an environment of team care, outcomes data and treatment protocols.

The following from an August 2, 2016 article in *Modern Healthcare* entitled "After 20 Years, What's Next for Hospitalists" offers an illustration of the hospitalist's role:

"If a 70-year-old patient comes into a hospital with a fractured hip and in need of orthopedic surgery, the hospitalist would manage that patient's treatment by taking into account not just the injured joint but any other comorbidities that an elderly patient might have, such as heart failure that increases their risk of a blood clot."

Likened to orchestra conductors, hospitalists coordinate the interaction of patients, physician specialists, non-physician clinicians, support staff, data, and protocols to (ideally) improve throughput, resource utilization and quality of care. A hospitalist might work with nurses on ways to reduce falls, develop measures for treating pneumonia or write up insulin drip protocols. For these reasons they are a natural fit for Accountable Care Organizations (ACOs) which are predicated on team-based and quality-driven principles of care. **Almost one in four hospitalists are now in ACOs, according to a 2016 Medscape Hospitalist Compensation Report** (see *Hospitalists: Riding the Wave of Changes in Healthcare. Medscape, April 26, 2016*).

The use of hospitalists also has increased as a key component of physician recruiting and retention. A growing number of physicians, particularly younger physicians, place great emphasis on a "controllable

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lifestyle,” including set hours and the reduction or elimination of hospital inpatient duties. This trend is illustrated by Merritt Hawkins’ *Survey of Final-Year Medical Residents*, in which physicians in their last year of training identified “lifestyle” and “personal time” as among their top priorities in a practice setting, trailing only the geographic location of the practice (see below):

Factors of Most Importance to Medical Residents When Considering a Practice Opportunity

Geographic location	69%
Lifestyle	61%
Adequate call/coverage/personal time	60%
Good financial package	58%
Proximity to family	48%
Good medical facilities	48%
Specialty support	32%
Educational loan forgiveness	19%
Low malpractice area	18%

Source: Merritt Hawkins 2015 Survey of Final Year Medical Residents

It is extremely difficult in today’s market to recruit physicians to practice opportunities that do not feature a hospitalist program. Indeed, traditional internal medicine that includes inpatient work is one of the most difficult, if not the most difficult, search assignment Merritt Hawkins now conducts.

For these and related reasons, 75% of all hospitals now have a hospitalist program, including nine out of 10 hospitals of 200 beds or more (see *Hospitalists: Riding the Wave of Changes in Healthcare. Medscape, April 26, 2016*)

Who Are Hospitalists?

There are, as yet, no residency programs in hospital medicine. In addition, hospital medicine does not have a separate certifying board under the American Board of Medical Specialties, “though the boards of internal medicine and family medicine have created a recertification pathway specifically measuring hospitalist skills. The pathway, called Recognition of Focused Practice in Hospital Medicine (RFPHM) was approved in 2009, and some hospitalists have already used this pathway for their maintenance of certification process.” (see *Hospitalists: Riding the Wave of Changes in Healthcare. Medscape. April 26, 2016*).

The Society for Hospital Medicine (SHM) reports that **approximately 77% of physicians practicing as hospitalists were trained in general internal medicine, 9% in family medicine, 6% in pediatrics and 8% in some other specialty.**



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Going Beyond Primary Care

The hospitalist concept has expanded in recent years and is no longer applicable to just primary care. The model migrated first to obstetrics/gynecology. “Laborists” are OB/GYNs who work at the hospital and perform deliveries, often for patients who do not have a regular OB/GYN or to relieve office-based OB/GYNs of off-hour deliveries.

Neuro-hospitalists provide stroke care for emergency department patients, surgical hospitalists (also called acute care surgeons) take the place of community surgeons taking call, while “transitionalists” or “SNFists” see patients in post-acute settings such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and long-term care hospitals. Transitionalists can be particularly important to preventing hospital readmissions, for which there are now financial penalties. Some endocrinologists today prefer to schedule protocols and don’t go to the hospital, handing off their patients to an endo-hospitalist instead.

An emerging concept to address the increased morbidities of hospitalized patients is the “comprehensivist.” In this model, a subgroup of hospitalists manages the care of a small panel of the highest risk, most frequently admitted outpatients, and remain involved when hospitalization is required (see *The 20th Anniversary of the Hospitalist. New England Journal of Medicine. September 15, 2016*). This approach dovetails with the concept of population health management, in which healthcare organizations take a more hands on role in patient education, compliance and care management that extends beyond the hospital’s walls. Hospitalists today also may be involved in the co-management of surgical patients in the hospital.

Work Settings and Schedules

According to Medscape, “Hospitalists are working in larger institutions. Employment with private multispecialty or primary care groups fell from 14% in 2007 to 5.6% in 2015, according to a report by the SHM. Meanwhile, almost one half of hospitalists were employed by hospitals in 2015, up from one third in 2007. Large hospitalist companies, which employ or manage hospitalists on behalf of hospitals, account for more than one quarter of all hospitalists, up from 19% in 2007.” (*Hospitalists: Riding the Wave of Changes in Healthcare. Medscape. April 26, 2016*).

The typical work pattern for hospitalists is a schedule of seven days on, including some night shifts (though “nocturnists” may work the late night shifts at some hospitals), followed by seven days off. Some hospitalists may use their week off to moonlight. The 7-on, 7-off schedule is now undergoing reconsideration, however, by those who believe it is too exhausting for some physicians and too difficult to modify. In addition, it implies that once the hospitalist is “off” his or her connection to the hospital is entirely discontinued until the next shift. Some observers have noted the hospitalist model works better when hospitalists remain engaged with the hospital during their “off” times, if not in patient care than in value-added leadership and quality-enhancement efforts.



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Recruiting and Compensation

Hospitalists remain one of the most in-demand type of physicians in the United States. Merritt Hawkins' 2016 *Review of Physician and Advanced Practitioner Recruiting Incentives* includes data from 3,342 search assignments the firm conducted from April 1, 2015 to March 31, 2016. In that 12-month period, hospitalists ranked fourth on the list of our most-requested search assignments (see list below).

Merritt Hawkins Top 10 Most Requested Searches April, 2015 – March, 2016

1. Family Medicine
2. Psychiatry
3. General Internal Medicine
- 4. Hospitalist**
5. Nurse Practitioner
6. OB/GYN
7. Neurology
8. Orthopedic Surgery
9. Urgent Care
10. Pediatrics

During that period, Merritt Hawkins conducted more searches for hospitalists (228 searches) than it has in any comparable time period in the past.

Demand for hospitalists is being driven by the factors referenced above and continues to be strong despite the fact that many hospitals are emphasizing outpatient services. Even if inpatient services are reduced, hospitals must have inpatient services covered 24/7, creating the need for hospitalists. Many smaller hospitals, which may have been reluctant to create hospitalist programs in the past, now find they cannot recruit primary care physicians to the community without such a program. This includes pediatricians, many of whom today are reluctant to assume inpatient duties. When "old-school" primary care doctors who have maintained inpatient practices retire, smaller facilities will face additional pressure to add hospitalists.

Because of a dearth of physicians, some facilities will likely turn to nurse practitioners (NPs) and physician assistants (PAs) to supplement hospitalist services. According to the SHM, use of NPs and PAs in hospitalist programs rose from 53.9% in 2012 to 65.9% in 2014.

Demand also is being driven by the fact that some hospitalists are complaining of burn-out as their duties increase and are asking for caps in their contracts on the number of patients they see per shift. This essentially reduces overall FTEs and creates the need for additional hospitalists.

At the same time, a growing number of primary care physicians have given up inpatient work and therefore may not be considered as candidates for hospitalist positions. Most hospitals want candidates who have



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recent experience with inpatient work, and many primary care physicians today have not seen inpatients for years, reducing the overall supply of viable candidates.

Supply for permanent hospitalist positions also is constrained by the fact that many hospitalists are attracted to temporary (locum tenens) work. Since hospitalists don't maintain continuity with patients in any case, some see no reason why they should not work as locums. All these factors combine to make hospitalist searches increasingly competitive.

The competitive nature of hospitalist searches is reflected in rising hospitalist starting salaries. The chart below illustrates the increase in hospitalist starting salaries over the last several years as tracked in Merritt Hawkins' *2016 Review of Physician and Advanced Practitioner Recruiting Incentives*:

Average Hospitalist Starting Salaries

	Low	Average	High
2015/16	\$180,000	\$249,000	\$450,000
2014/15	\$170,000	\$232,000	\$300,000
2013/14	\$145,000	\$229,000	\$350,000
2012/13	\$150,000	\$227,000	\$350,000
2011/12	\$160,000	\$221,000	\$400,000

Source: Merritt Hawkins 2016 Review of Physician and Advanced Practitioner Recruiting Incentives

Listed below is average compensation for hospitalists as tracked by various other sources, as well as by Merritt Hawkins.

Average Hospitalist Compensation

American Medical Group Association	\$275,363
CompData	\$223,600
ECG Management	\$256,481
Hospitals and Healthcare Compensation Service	\$278,010
Sullivan Cotter	\$277,233
Merritt Hawkins	\$249,000

In addition to base salaries, hospitalists generally are provided with sign-on and production bonuses. A Merritt Hawkins' client in the Midwest recently offered a hospitalist a \$275,000 salary with sign-on and production bonuses creating a potential annual compensation of \$350,000. A private practice Merritt Hawkins client, also in the Midwest, recently offered a hospitalist a \$250,000 salary. However, partners in the practice are making \$350,000 and it is the practice potential that has drawn interested candidates.

It is to the advantage of hospitals, hospitalist groups, and others seeking hospitalists that many physicians,



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particularly in internal medicine, are expressing an interest in hospital medicine. By the same token, it should be considered that the growing number of primary care physicians (particularly general internists) choosing hospitalist positions reduces the number available for office-based practices, where they also are needed, so in primary care recruitment today it is often a case of “robbing Peter to pay Paul.”

CONCLUSION

A variety of healthcare trends, including the drive toward a more value-based delivery system and the practice preferences of many physicians, are causing continued demand for physicians practicing hospital medicine, both in primary care and a variety of other specialties. Despite the current volatile nature of the healthcare market, these trends can be expected to continue.



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About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- ❖ Psychiatry: "The Silent Shortage"
- ❖ Physician Supply Comparisons: Physicians by Select Specialties Practicing in Each State and Licensed in Each State but Practicing Elsewhere
- ❖ The Aging Physician Workforce: A Demographic Dilemma
- ❖ Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- ❖ The Physician Shortage: Data Points and State Rankings
- ❖ Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- ❖ RVU FAQ: Understanding RVU Compensation in Physician Employment Agreements
- ❖ The Economic Impact of Physicians
- ❖ Ten Keys to Physician Retention
- ❖ Trends in Incentive-Based Physician Compensation

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