Canadian Hospitalists

Who they are, what they do, and how they can help you achieve your organizational objectives

PREPARED BY HOSPITALIST CONSULTING SOLUTIONS INC

introduction

The number of hospitalist programs across Canada has been growing over the past 10 years[1], and many hospitals (large and small) are adopting this new model. A similar trend has occurred in the United States, where there has been an explosion of this new model of care in many organizations[2].

Despite this continuing growth, there are still many challenges to the adoption and sustainability of hospital medicine programs in Canada. In some jurisdictions, tensions continue to exist between some primary care providers and hospitalists. At times, these tensions have been played out at provincial organizations and in the public[3]. While in the United States the attitude of primary care practitioners towards hospitalists has been generally positive, anecdotal evidence suggests that in Canada this relationship continues to be affected by tensions over perceptions, job descriptions and compensation.

At the same time, many hospital administrators continue to question the value of investing in such programs. As a result, some organizations have been reluctant to support the creation of hospital medicine programs despite facing severe challenges in finding physicians willing to provide inpatient care.

For both groups of skeptics, lack of understanding of who hospitalists are, how they work, and what value they can bring to the organization and the broader healthcare system plays an important role in perpetuating unhealthy misconceptions. This paper provides an introduction to the hospitalist model of inpatient care and outlines the value proposition of hospitalists and hospital medicine programs.

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Who is a hospitalist, and what does a hospitalist do?

Hospitalists are physicians who primarily work in a hospital setting and provide care to patients admitted to hospital. They look after inpatients during their acute illness, as well as those in rehab facilities or waiting for alternative levels of care. And while most hospitalists act as the "most responsible physician" for admitted patients, many also provide consulting services to other physiciangroups (such as surgery and psychiatry). Some hospitalists also operate post-discharge clinics.

Similar to Emergency Medicine or Critical Care, hospital medicine is a "site-based" specialty. What distinguishes hospitalists from other physician groups (such as traditional family physicians or subspecialists) is:

- Unlike most traditional physicians who only come to hospitals occasionally or infrequently, hospitalists spend the majority of their clinical time in hospitals.
- Hospitalists develop specialized knowledge of the common clinical conditions encountered in inpatient settings, and develop enhanced competencies in areas of diagnosis, treatment and procedures of acute clinical medicine.
- In addition to a specialized clinical knowledge base, hospitalists develop an in-depth understanding of the processes of care delivery in an organization, and participate in (and frequently lead) clinical and non-clinical improvement efforts. Some examples include participating in various hospital committees, standardizing care through development of pre-printed order sets or care pathways, and improving patient flow through enhanced admission processes and improved discharge planning.

There is no consensus definition for "hospitalist" or "hospital medicine" in Canada, and it is not uncommon to come across a different understanding of the above terms depending on geography (rural vs. urban) or the hospital setting (community vs. teaching).

In the United States, the Society of Hospital Medicine defines hospital medicine as " A medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients. In addition to their core expertise managing the clinical problems of acutely ill, hospitalized patients, hospital medicine practitioners work to enhance the performance of hospitals and healthcare systems by:

- Prompt and complete attention to all patient care needs including diagnosis, treatment, and the performance of medical procedures (within their scope of practice).
- Employing quality and process improvement techniques
- Collaboration, communication, and coordination with all physicians and healthcare personnel caring for hospitalized patients
- Safe transitioning of patient care within the hospital, and from the hospital to the community, which may include oversight of care in post-acute care facilities.
- Efficient use of hospital and healthcare resources"

Reference: www.hospitalmedicine.org

Who provides "hospitalist" care in Canada?

Like their counterparts in the United States, physicians who practice as hospitalists in Canada come from a diverse background[4]. By and large, Canadian hospitalists are "generalist" physicians who have trained in family medicine, general internal medicine or pediatrics.

General internists have been working as hospitalists in many large, academic centres in Canada for decades[5]. In many urban teaching hospitals, internists have been supervising house-staff and medical students in Clinical Teaching Units and working essentially as hospitalists. Some organizations have even created non-teaching hospitalists services staffed by internists in parallel to their CTUs[6]. However, the emergence of internist-run hospitalist programs in community hospitals is a more recent phenomenon that parallels the broader growth in the hospitalist model across the country. The Ontario MRP Expert Panel estimates that in the Greater Toronto Area (GTA), up to 40% of hospitalists are trained as general internists[7], although surveys conducted by the Canadian Society of Hospital Medicine suggest the percentage of internist hospitalist is about 10% nationally[7].

What is also new in Canada is the emergence of hospitalist programs in an increasing number of community hospitals. Traditionally, community-based family physicians had provided the majority of inpatient care in such organizations. However, over the past decade more and more family physicians have focused their practices on the outpatient setting. As a result, many organizations have adopted the hospitalist model and in the majority of cases hospitalists who staff such programs come from a family medicine background. Across Canada, the number of hospitalists is estimated to be close to 2000, and 90% have been trained as family physicians[8].

In addition to general internists and family physicians, some pediatricians also work as hospitalists in Canada[9]. For example, the Hospital for Sick Children in Toronto has had a hospitalist program since the late 1980's, and many other children hospitals in Canada have also adopted this model.

Canadian hospitalists tend to be younger and include more female physicians[1]. Since the majority of hospitalists in Canada come from a family medicine background, hospitalists in Canada tend to be more involved in co-managing patients with psychiatrists and provide newborn care[7].

How did hospitalist programs come about in Canada?

It is widely accepted that the immediate reason why hospitalist programs were developed in various jurisdictions in Canada has been the problem of increasing numbers of unattached patients [10-11]. According to the College of Family Physicians of Canada, close to 5 million Canadians are without a family doctor [12]. The Ministry of Health and Long Term Care estimated that 7 % of the population in Ontario was "unattached" in 2009 [13]. However, the true magnitude of the number of unattached patients is likely significantly higher than those suggested, since many community physicians have limited their practices to ambulatory care and have given up their hospital privileges, effectively leaving their patients without a designated physician for hospital-related care needs[14].

There are many reasons why many community family physicians have chosen to limit their practices to the outpatient setting:

1 **Demographic shifts in physician workforce:** The Canadian physician population has been getting older. In 1997, fifty percent of physicians in Ontario were 45 years or older [11]. However, by 2009, this number had increased to 65.9% of the physician workforce in the province [15]. Additionally, from 1990 to 2009, the percentage of women entering medical schools across Canada increased from 44.0% to 57.9% [16].

2 **Declining numbers of family physicians:** From 1993 to 2000, Canada witnessed a drop in the physician to population ratio of 5.1 % [17]. The College of Family Physicians in Canada estimates that in 2006, 4.6 million Canadians did not have a family physician[11]. This shortage of Family physicians can be attributed in part to the demographic changes discussed above. Another contributing factor to this overall decline is the attitudinal changes of medical school graduates. From 1994 to 2003, the percentage of Canadian medical graduates who chose family medicine as their first career choice progressively declined from 32.4% to 24.8%[18]. While this trend has since reversed to some extent, only 33% of Canadian graduates picked family medicine as their first choice during the first iteration of the 2010 residency match[19].

3 **Changing attitudes towards work-life balance amongst physicians:** Increasingly, physicians are identifying family and quality of life as issues with higher priority than work responsibilities. This is in part reflected by changes in work hours: younger physicians in Manitoba provided 20% fewer visits per year in 2000/01 than their same-age peers did 10 years prior[20]. While fewer students are enrolled in medical schools, and still fewer choose family medicine, those who do are also likely to work fewer hours and place a higher degree of importance on work-life balance. The result is a compounded effect of family physician shortage in communities across Canada.

4 **Declining comprehensiveness of family medicine:** In addition to the demographic and attitudinal changes of primary care physicians, we can also observe significant changes in the field of family medicine itself. One observable change is a growing trend towards fragmentation of family medicine and in effect, a process of "sub-specialization". Family doctors are increasingly moving away from a "generalist" practice, and are focusing their activities on particular fields [8, 21] Glazer, CFPC 2003. For example, a study of family physicians in Ontario showed that Female physicians were more likely than male physicians to deliver babies and significantly less likely to be performing all other non—office-based services [22]. In the 2007 National Physician Survey, 29.5 % of Family Physician or General Practitioner respondents identified themselves to have a focused practice in areas such as Emergency medicine, Geriatric medicine, Obstetrics and Palliative care[23]. One implication of this trend is that having access to a family physician does not necessarily guarantee that the patient will be looked after by their own doctor in the event

5 **Increasing pressures on hospitals for efficiency and cost reductions:** the Canadian healthcare system has undergone significant changes in areas of infrastructure, capacity and governance. The increasingly older population has resulted in significant increases in demand, while the overall system capacity has either declined or at best remained unchanged[24]. This has necessitated unprecedented levels of efficiency and an increasing shift towards cost containment. Over the past 2 decades, there has been a steady decline in the number of acute hospital medicine beds in Canada[8, 18]. At the same time, healthcare spending has increased across the country[25]. The need for increasing efficiency in the system requires major re-thinking on how the system is organized and how various players, including physicians organize their practices and are compensated for their services. This also means that the traditional relationship between physicians and hospitals needs to be redefined, and new models of collaborative interactions explored.

6 **Focus on quality, safety and value:** The healthcare systems in many countries are witnessing a major shift in expectations of consumers, payers and practitioners with respect to quality and safety. The Institute of Medicine's ground breaking publications "To Err is Human" and "Crossing the Quality Chasm" outlined the human costs of medical errors and encouraged major rethinking of how medical care is delivered and the system is designed to ensure high levels of safety, reliability and quality. In Canada there has been a proliferation of organizations and agencies responsible for assessing, monitoring and improving care (such as provincial health quality councils), with increasing levels of public reporting of quality metrics and implementation of novel approaches to medical spending (such as pay for performance schemes). Hospitals are particularly being subjected to increased levels of accountability on quality and safety of care[26]. To meet such requirements, hospitals will need to explore innovative ways of engaging their medical staff[27]. Developing new models of care delivery can help hospitals bridge this "engagement gap" through integrated relationship with medical staff. Hospitalists in North America have taken a leading role in improving quality and safety through their involvement in improvement projects and collaboratives, and have proven themselves to be the natural partners for organizations to advance

The reasons behind the growth of hospital medicine in Canada are different than those in the United States. In the United States, hospitalist programs were developed primarily to reduce cost of hospitalization by improving efficiency in the inpatient system. Over time, other benefits of the hospitalist model (better quality of care, improved patient satisfaction, and improved physician integration in the hospital operations) have helped enhance the development of this field to an astonishing level: the Society of Hospital Medicine estimates the number of practicing hospitalists to be more than 30,000.

In the Canadian healthcare system, a number of major shifts have occurred over the past 10–15 years that have lead to the adoption of hospitalist programs. While some of these major systematic changes have driven the creation of new models of hospital care delivery (namely the development of hospitalist programs), others have helped sustain and grow the adoption of these models. Unless these potent drivers for change cease to exist or such trends reversed, the hospitalist model will continue to grow across the country.

What are the benefits of hospitalist programs?

Canadian hospitalists have played an important role in our healthcare system by ensuring that patients admitted to hospitals have access to medical care. But the value of hospitalists goes beyond just acting as most responsible physicians for inpatients (when primary care physicians and specialist have increasingly moved away from that role). The hospitalist model has shown a promise for better resource utilization and quality of care.

Better Efficiency

There is now a significant body of evidence for the effectiveness of the hospitalist model in reducing length of stay and cost. A large 2007 study of 76,926 patients in the United States that compared care provided by hospitalists to those provided by internists and family physicians showed that hospitalists had shorter lengths of stay, and the cost of hospitalization was less than that of internists but similar to family physicians[28]. Similar mortality and readmission rates were observed among these groups. A large systematic review also showed lower length of stay and cost per patient for hospitalist patients, with some evidence for better quality of care measures[29].

There is a lack of formal published data from Canadian hospitalist programs. A study of a program in Burnaby, British Columbia showed that the introduction of a hospitalist program resulted in a 27.6% reduction in length of stay and a 50% reduction in the readmission rate to hospital[30]. However in our experience with many programs in Canada, hospitalists have shown significant improvements in efficiency and resource utilization.

Better quality of care

An important value added aspect of the hospitalist model is the potential for better quality of care. Since hospitalists develop specialized knowledge of acute medical conditions, they are more likely to provide care consistent with established best practices. While there is little research in this area, there are indications that hospitalists may improve some aspects of care for patients admitted with conditions such as congestive heart failure[31].

However, what is clear is that hospitalists are taking an active leadership role in systematically improving quality and safety in health care[32]. Despite the fact that the Canadian Hospital Medicine "movement" is still in the early stages of its development, many hospitalists are heavily involved in QI work across the country through their participation in various committees and projects. Quality Improvement and patient safety are now an integral part of hospital medicine in Canada.

Conclusions

Hospitalist programs are growing in numbers, and many organizations are benefiting from investing in creating successful programs. While such programs require financial support from the organization, hospitals are increasingly realizing the value added benefits of hospitalist programs. Hospitalists have been shown to improve efficiency and cost reductions, and due to their close relationship with their healthcare institutions, they are the natural partners for organizations that are seeking to meet increasing regulatory and public demands for better quality at a time of fiscal restraints.

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25 In Ontario, the Ministry of Health and Long Term Care estimates that if the current trends continue, by 2022 seventy cents of every dollar will be spent on health-care.

26 For example, the recent Excellent Care for All act introduced in Ontario proposes to introduce fundamental changes in how quality and safety is organized in hospitals, with requirements for enhanced board engagement, annual publicly available quality improvement plans, and pay for performance mechanisms for senior managements. Ministry of Health and Long Term Care. http://www.health.gov.on.ca/en/legislation/excellent_care/excellent_qa.aspx

27 Traditionally, lack of participation by physicians in system change efforts has been described as a barrier to implementation of quality improvement initiatives in hospitals. Some observers have identified the traditional working relationship of physicians and hospitals as one reason for this apparent lack of "engagement". Yet, it is widely acknowledged that physician participation and leadership in quality and safety projects is critical to their success, as almost all actions in medicine, especially in acute care settings, derive from decisions made by physicians in one way or another. For more details, see the following references:
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32 For example, the Society of Hospital Medicine has created a number of major improvement initiatives and continues to provide valuable resources for hospitals and hospital medicine practitioners. www.hospitalmedicine.org

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