

Confronting the Hospitalist Workforce Shortage

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Background

A group of the nation's leading hospitalists has emerged that share many common perspectives and are sensitive to the issues that directly affect private practitioners of hospital medicine. The authors of this white paper convened Sept. 25-26 in Phoenix, Arizona as an organization they have named The Phoenix Group. Formed as an action-oriented think-tank, The Phoenix Group's mission is to provide executive leadership to address the most serious challenges facing private practice hospitalists in the U.S. today. This was the Phoenix Group's second gathering, the first having taken place in March 2007.¹ The group intends to meet in Phoenix for a retreat each spring and fall, with ongoing dialog and discussion throughout the year.

The Phoenix Group membership collectively represents almost 2,000 hospitalists which, according to the Society of Hospital Medicine [SHM] statistics, comprise over 20% of hospitalists working in some form of a private practice setting. The inspiration for The Phoenix Group was the success in the 1980s of the now famous Jackson Hole Group, whose ideas came to form the basis of today's managed care programs.

The primary focus of this meeting was on the issue of

workforce shortage and the impending workforce crisis. It is the general consensus of the group that no issue is in need of more attention than the workforce shortage; therefore we will focus this white paper on our examination of this topic.

Discussion

Organizations responsible for planning the future of Hospital Medicine have been largely silent about the effects on physician supply created by the unbridled growth of our specialty. The hospitalist leadership has paid too little attention to the emerging workforce issue. While it is true that the antecedents lay in the decisions to constrict the supply of primary care physicians in the 80s and 90s, well before the emergence of our specialty, it is equally true that the shortage has been looming for years. All hospitalist employers and hospitalists themselves, regardless of their employment model, are feeling its effects.

Rosy predictions of a 50-100% workforce increase² overlook the real constraints that private practice hospital groups have to contend with every day. On the demand side, The SHM speculates that the need for hospitalists could reach 40,000 or higher over the next five years, a number which seems achievable only in the most

theoretical sense.³ Such predictions are disconnected from the reality that filling demand for these numbers of hospitalists is nowhere in sight. Indeed, our immediate concern is that the current workforce, estimated at 20,000, may well be close to a peak. It is not altogether implausible that a few years hence we may be looking back at 2008 as a high-water mark and wondering in retrospect what might have been done to prevent a workforce contraction.

Causative forces are multiple, including an indifferent attitude toward hospitalists in the medical education community, poor training of residents as to how meaningful and rewarding a hospitalist career can be, poorly managed compensation programs that stifle productivity and reward inefficiency, hardened and outdated attitudes toward mid-level providers and outdated visa restrictions, to name just a few. The fact is that the growth rate of hospital medicine stands in stark contrast to the fact that only one resident in fifteen studying internal medicine actually chooses to become a hospitalist,⁴ and all too often it is not their first choice. With a median job duration of only three years,⁵ many new hospitalists view their first job merely as a way station toward another specialty or perhaps toward relocation. This view makes some employers wary of investing in the very training and education so critically needed by the young hospitalist.

Collectively, The Phoenix Group membership encounters the vast majority of residents in the U.S. considering a career in Hospital Medicine. It has not escaped our attention that competition for hospitalists is entering a new, more competitive phase, diverting employer resources to recruiting and marketing that they can ill afford and does little in itself to benefit our specialty. The physician shortage has instigated a frenzy of practice groups amidst a shallow pool of new recruits that in itself may further alienate residents and drive them away from a career in Hospital Medicine.

Exacerbating the confusion about Hospital Medicine job opportunities among residents is survey data that circulates absent of proper context or explanation which implies to the would-be hospitalist that he will need only to see an average of 12 patients per work period.⁶ The Phoenix Group invites an appropriate clarification and

disavowal of arbitrary constraints to a productive hospitalist's work schedule. Residents may also find it disheartening to learn that two-thirds of hospitalists under 50 years old would not be willing to work longer hours for more pay⁷ and indeed would reduce their work hours if they could afford to.

Closing the Productivity Gap

After much discussion, The Phoenix Group has concluded that the gap between workforce supply and demand is, at least in part, a productivity gap. The realistic search for solutions to improve the productivity of hospitalists is the key challenge facing our profession today. It is helpful to bear in mind that managers in many high-growth professions facing workforce shortages confront this very issue. Hospital Medicine is hardly the first business to experience a supply-demand mismatch. Nor are hospitalists the only professionals desiring more pay for less hours. The workforce productivity issue is really a classic management issue and therefore requires that we engage in a process of resolving these issues with proven and effective management techniques.

Solutions to the workforce shortage cannot rest solely upon efforts to increase the supply of new hospitalists, which under the best of circumstances will take many years to bear fruit. A comprehensive plan to improve productivity while simultaneously improving job satisfaction may be more likely to yield faster, more permanent and more achievable results. This is a challenge that The Phoenix Group members are committed to pursuing. Our internal consensus is that a properly managed mix of solid training, intelligent scheduling, improved workflow design and effective compensation programs may result in hospitalists improving productivity significantly above the reported national mean. If these theories could be demonstrated on a larger scale then the impact on Hospital Medicine would be profound. Productivity improvements hold the promise of largely offsetting the so-called shortage of hospitalists, while freeing up funds for higher levels of physician compensation in the process.

Further Calls to Action

Other important initiatives are required to bridge the gap between supply and demand. The Phoenix Group recommends that the following receive immediate consideration:

- a) A proactive effort to tap into the available pool of more than 100,000 Family Practitioners and D.O.s in the U.S. today. This will require a campaign to change the mindsets of referral partners, hospital administrators and other stakeholders to embrace osteopathic and non-internal medicine physicians as hospitalists, which in turn will require training programs geared toward these specialties to develop them into seasoned hospitalists.
- b) An organized campaign to convert more mid-level providers. There is a talent pool of 65,000 Physician Assistants and 120,000 Nurse Practitioners in the U.S. today waiting to be tapped to play a meaningful role in Hospital Medicine. Rules and standards vary on a local basis and a stepped-up effort to promote more liberal use of extenders will be required. Again, the success of these efforts will at least in part be predicated on better training programs for extenders to gain the support of all stakeholders.
- c) Advocacy for faster issuance of new state licenses. Rules and operations vary on a state-by-state basis but the bureaucracy must be made more responsive to unclog the backlog of licenses waiting to be issued.
- d) Forceful advocacy and more effective lobbying for changes in visa laws to allow a greater number of foreign nationals into the U.S. healthcare system. This effort should be coupled with an effort to gain greater acceptance of International Medical Graduates in hospitalist programs by all stakeholders, including inpatients and hospital administrators.
- e) Wherever possible, ease the administrative burden on hospitalists, who in our estimate may be spending as much as 65% of their work hours performing non-clinical activities. Perform a careful cost-benefit analysis for the use of administrative help such as clinical care

coordinators, administrative support and technology to improve workflow.

- f) Practice groups can help themselves with more effective scheduling policies, utilizing the limited resource of hospitalists more efficiently and deploying hospitalist resources only when it is truly needed. Limit the pursuit of marginal opportunities. Decisions about night coverage in particular needs to be made very prudently, especially for smaller facilities.

Conclusion

Private hospitalist enterprises such as those comprising The Phoenix Group are at risk as long as the workforce issue remains unaddressed. Like any economic enterprise, private practice hospitalist groups seek the stability and predictability that the key resources needed to drive future growth will be available.

Hospital-employed Hospital Medicine groups and large academic institutions may be able to tolerate workforce inefficiencies through subsidies and cost transfers, but we cannot. The fundamental economic mandates of supply and demand that we face every day tell us loud and clear: the physician shortage is here and now and a lack of leadership on this issue may pose a direct threat to the economic future of hospital medicine. In the end, even the largest institutions and practices will suffer under the weight of provider shortages.

We note with sincere appreciation that the SHM recently convened its first meeting on the subject of the workforce shortage. We remain hopeful that action-oriented next steps are soon to follow.

We will need bold and experienced leadership and management to avert the impending crisis of the workforce shortage that has already begun to descend upon us. If Hospital Medicine were to fail in its promise of becoming a centerpiece in the future of inpatient care in America, it would be due to the lack of adequate planning, resourcefulness and imagination in adapting to our constrained physician supply. The leaders of Hospital Medicine from all sectors will need to lead this effort or

jointly suffer the consequences of our inaction. The Phoenix Group will continue to do its part and bring to the fore issues which its members consider vital to our profession. In future meetings we will turn our attention to other key issues; our next meeting is scheduled for March

2008. We look forward to continued dialog with the hospitalist community and the broad spectrum of healthcare players to do our part to secure the future of Hospital Medicine.

¹ The group published its first white paper in May 2007, go to www.phoenixgroupwhitepaper.com

² SHM editorial, "Where Will We Find 50,000 Hospitalists?", The Hospitalist, Aug. 2007

³ As an exercise in theoretical demand, assume that there are 35 million admissions in the U.S. per year, of which 70% are candidates for hospitalist care. Assuming an average LOS of 5.5 days and that each doctor has 300 patient visits per month, that would imply a theoretical demand of 38,000 hospitalists, or twice the current workforce.

⁴ACP/AAIM compiled data 2005

⁵ SHM survey 2006

⁶ SHM survey of hospitalists 2005-06

⁷ AAMC survey 2006

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