ACGIM Hospitalist Survey 2007

1. What is your name and title (i.e. director of hospitalist group, division chief of GIM, etc)?		
		Response Count
		45
	answered question	**45**
	skipped question	**0**

2. What is the name of your hospital/health system?		
		Response Count
		45
	answered question	**45**
	skipped question	**0**

3. If we have questions about your responses - what is your contact email address?		
		Response Count
		44
	answered question	**44**
	skipped question	**1**

4. What was/is the number of full-time equivalent (FTE) hospitalist faculty in your group? (no fractions/decimals- whole digits only)				
		Response Average	Response Total	Response Count
This year (2007)		**14.82**	**667**	45
2 years ago (2005)		9.89	445	45
			answered question	**45**
			skipped question	**0**

5. Do you have a non-housestaff hospitalist service (i.e. faculty provide direct inpatient care without the support of housestaff/residents)?

		Response Percent	Response Count
Yes		**64.4%**	29
No		35.6%	16
	answered question		**45**
	skipped question		**0**

6. At what hospital is your non-housestaff service based?(may choose more than 1 if your group covers more than 1 hospital)

		Response Percent	Response Count
Major Teaching Hospital for the main IM Residency Program		**88.0%**	22
Minor Teaching Hospital for the main IM Residency Program		12.0%	3
Affilitated Hospital (not a teaching site for the main IM Residency Program)		4.0%	1
	answered question		**25**
	skipped question		**20**

7. How do you staff the non-housestaff hospitalist service? (you may chose more than 1 option)

		Response Percent	Response Count
Hire dedicated faculty for non-resident work		26.9%	7
All hospitalists share non-resident work equally		26.9%	7
All hospitalists do non-resident work but some do more than others		**46.2%**	12
Some (but not all) hospitalists do non-resident work		23.1%	6
		answered question	**26**
		skipped question	**19**

8. If you answered that your faculty share non-housestaff work among the group - please list the percent (%) of time a typical hospitalist in your group spends in each activity

		Response Average	Response Total	Response Count
Non-resident service		**46.82**	**1030**	22
Resident (teaching) ward service		30.10	602	20
Consult or comanagement service		13.95	279	20
Outpatient clinical work		3.61	65	18
"Protected" or "Academic" time		14.47	275	19
			answered question	**22**
			skipped question	**23**

9. For your non-housestaff service please provide the following data for that service.

		Response Average	Response Total	Response Count
Number of Full-time (FTE) equivalent faculty?		8.52	213	25
Number of mid-level provider FTEs (NP or PAs)?		2.96	74	25
Number of discharges/year covered by non-resident service?		**2228.57**	**46800**	21
			answered question	**25**
			skipped question	**20**

10. For your non-housestaff hospitalist faculty please provide the following metrics.

		Response Average	Response Total	Response Count
Total patient encounters (i.e. billable encounters) per day per faculty		12.09	266	22
Average daily census for the entire non-housestaff service		**35.04**	**806**	23
Number of faculty working during the day on the entire service		3.35	77	23
Number of faculty (or moonlighters) working at night on the entire service		1.39	32	23
			answered question	**23**
			skipped question	**22**

11. How do you provide in-house nighttime coverage for your non-housestaff service? (you may check more than 1 box)

	Response Percent	Response Count
Dedicated nocturnist (i.e. work nights only) faculty	40.0%	10
Moonlighters	**48.0%**	12
Nights shared among hospitalist faculty	36.0%	9
N/A - we do not have in house night coverage	16.0%	4
	answered question	**25**
	skipped question	**20**

12. For a full-time hospitalist working on the non-housestaff services please answer the following schedule questions. If your hospitalists do both resident and non-housestaff based work, please answer here for what they do during a month where they work only on the non-housestaff service

	Response Average	Response Total	Response Count
Total Shifts worked per month	**14.50**	**348**	24
Weekends worked per month (answers can be 0 to 4)	1.79	43	24
Night shifts worked per month	1.79	43	24
		answered question	**24**
		skipped question	**21**

13. How do you schedule vacation and other personal time off (i.e. CME) for your non-housestaff service?

		Response Percent	Response Count
During "off" time within a fixed shift schedule (i.e. no flexability to change work schedule)		8.0%	2
During "off" time within a shift schedule but allow flexability to alter schedule		**76.0%**	19
Other system of scheduling		16.0%	4
		answered question	**25**
		skipped question	**20**

14. For your resident-based hospitalist services (i.e. ward attending time) please provide the following data

		Response Average	Response Total	Response Count
Encounters (billable encounter)per day per faculty		**13.29**	**412**	31
Months per year (average) of ward attending per full-time faculty		5.84	181	31
			answered question	**32**
			skipped question	**13**

15. Please provide the starting annual compensation rate (in dollars) for a full-time hospitalist in your group who does the following work. Please include salary and anticipated bonuses but do not include benefits. If an option does not apply (i.e. you have no faculty who do 100% non-housestaff or 100% resident work) simply leave that box blank.

		Response Average	Response Total	Response Count
100% non-housestaff work		**150714.29**	**2110000**	14
100% resident work		136952.38	2876000	21
Hybrid Job (mixed resident + non-housestaff work)		143333.33	2580000	18
			answered question	**33**
			skipped question	**12**

16. What is your financial support model with your hospital/medical center/medical school?

	Response Percent	Response Count
covers difference between costs and revenues only (i.e. zero "profit" margin)	34.3%	12
covers difference between costs and revenues plus extra transfer (i.e. "positive profit margin")	8.6%	3
set amount of dollar support regardless of deficit or profit (i.e. fixed transfer amount)	**42.9%**	15
other model of support	14.3%	5
no support	0.0%	0
	answered question	**35**
	skipped question	**10**

17. Does your hospitalist program run a profit?

	Response Percent	Response Count
No	**74.3%**	26
Yes	25.7%	9
	answered question	**35**
	skipped question	**10**

18. Do you think your current hospitalist positions in your group are sustainable?

	Response Percent	Response Count
Yes	**77.8%**	28
No	22.2%	8
	answered question	**36**
	skipped question	**9**

19. Do you think your current hospitalist positions will allow for successful academic promotion?

		Response Percent	Response Count
Yes		**71.4%**	25
No		28.6%	10
		answered question	**35**
		skipped question	**10**

20. What do you see as your biggest challenge(s) for your hospitalist group(examples: recruiting, sustainable jobs, academic outlets, etc)?

		Response Count
		34
	answered question	**34**
	skipped question	**11**

21. What methods are you using recruit outstanding hospitalists?

		Response Count
		29
	answered question	**29**
	skipped question	**16**

22. What are you doing to foster the academic promotion and growth of your hospitalists?

		Response Count
		31
	answered question	**31**
	skipped question	**14**

What do you see as your biggest challenge(s) for your hospitalist group(examples: recruiting, sustainable jobs, academic outlets, etc)?

#	Response Text
1.	1.salary support 2.sustainability
2.	Recruiting, implementing nonteaching service in the next year
3.	Recruiting high quality faculty who seek long term careers in this area. Otherwise similar issues as all other areas of academic GIM.
4.	acknowledgement of the institution of the important role we play and financial support of that role.
5.	Burn-out for the non-teaching hospitalists
6.	--recruiting --salaries outside of academic settings --convincing administration to support the program, given that it does not pay for itself
7.	recruiting, sustainable jobs constant pressure to evolve to fill voids or work that other physicians do not want
8.	sustainable jobs
9.	To qualify your dichotomous questions above, I think the academic jobs we have, even with some nonteaching time, are very sustainable and allow for academic promotion. The nonteaching-heavy or all nonteaching jobs are not sustainable (due to frequent nights, long shifts, and the current flaws with our nonteaching service) and not amenable to promotion (too little teaching time which is necessary for promotion). The nonteaching service is in the process of undergoing a significant revision due to its current unsustainability. We are hiring more faculty and more NPs. The goal will be 12-13 encounters per faculty member per day on the NTS. We are fortunate that hiring has not been a huge challenge but the nonteaching service has been a shock to the previously 100% academic group. We are also in need of a researcher(s) who can lead the scholarship aspects of our group.
10.	recruitment of truly academic providers lack of training and experience in QI (mostly with new hires) inability to make a sustainable academic model w/o more teaching opportunities
11.	Retention; academic outlets
12.	Developing clinical expertise among a very junior faculty to allow outstanding teaching and to foster academic productivity.
13.	1. recruiting 2. ensuring a sustainable schedule 3. academic and clinical mentoring 4. ensuring the instititіon values our professional goals
14.	recruiting and retaining stable group
15.	Recruitment of dedicated career hospitalists.
16.	No academic outlet. The dept chair and GIM section head promote it as an academic job but the reality is that it is nothing of the sort. Academic pursuits including teaching are consistently frowned against and the resident teaching opportunities are only grudgingly given when no one else can be found to fill them.
17.	Academic productivity
18.	maintaining hospital financial support
19.	Recruitment, job sustainability, and academic outlets are all important. The biggest challenge affecting job sustainability is that teaching institutions are often not well equipped (in terms of physician culture, nursing culture, or ancillary support) to have services of non-teaching patients. It's easy to feel like a glorified resident or a second-class citizen rather than an attending when the assumption of other physicians and allied health professionals is that direct patient care is provided by house officers and the job of the faculty is to oversee the care--not answer questions from nurses and enter orders into cumbersome provider order entry systems. Further, academic centers are often behind the curve in their adoption of physician-as-customer models of care, partly since housestaff constitute cheap labor. For example, in a community hospital, it's bad resource utilization to pay an attending to draw blood gases, so respiratory therapists will likely be doing ABGs. In a teaching hospital in which most patients are cared for by housestaff, it may not be cost effective to hire the extra respiratory therapist staff, and so physicians may be expected to draw blood gases. Cultural issues are also very important. For example, it's not uncommon in teaching institutions for there to be limited incentive for consultants to provide timely service and good

What do you see as your biggest challenge(s) for your hospitalist group(examples: recruiting, sustainable jobs, academic outlets, etc)?

#	Response Text
	communication. This contrasts with community centers where consultants need to provide good service or they won't be referred patients. Similarly, nurses in community hospitals often know better than to page the attending at night about a slightly confusing diet order, but in teaching institutions often have no hesitation to page the doc for any and all minor questions, whether that doc happens to be an intern or an attending. Housestaff tend to put up with these headaches since they know that they have no clout to demand better and they know they have much to learn (eg, how to do ABGs). Attendings get burnt out and feel like they aren't getting the respect the deserve. Finally, it can add insult to injury when productivity expectations are not adjusted to account for the extra work, and administrators ponder why their academic hospitalists can't see as many patients as their community counterparts.
20.	The non-resident hospitalist group is entirely separate from the training program and has issues of recruitment, burn-out, and enjoyment that are not my responsibility.
21.	long-term retention, increasing academic productivity
22.	recruitment and retention (salary is the driver)
23.	--the maintenance of Hospitalists and Generalists into a cohesive unit, ie.e., a house united --recruiting those interested in a career in Hospital Medicine (vs short-timers) --obtaining additional support from our 2 hospitals and our faculty practice for the creation and maintenance of financial support for a 24/7 uncovered hospitalist service --having quality/safety work formally integrated into our promotion critirea
24.	Balancing the needs of the hospital(service) and residency program (work hour restrictions).
25.	recruiting quality people interested in academics
26.	recruitment and creating sustainable positions
27.	different job types with different challenges (some more sustainable and will allow for successful promotion than others)
28.	academic outlets, sustainable schedule, integration into the traditional ward services
29.	-limited collaboration between School and Hospital -too many competing demands on limited hospitalists -limited academic promotability
30.	sustainable job for the individual and sustainable model for the division
31.	Academic outlets
32.	finding career hospitalists and not just new grads trying to find a fellowship spot
33.	Promotion

What methods are you using recruit outstanding hospitalists?

#	Response Text
1.	1.to develop resident association model
2.	Advertisements, word of mouth, have used recruter for one position
3.	Personal contacts with programs. Usual advertising.
4.	National advertising, selecting physicians with a hospitalist career interest, recruiting from our residency program
5.	--acp hospitalist --talk to previous medical students and residents --let our faculty know, so they can recruit --sgim website --letters to new grads using a paid service
6.	We try to recruit our excellent graduating residents.
7.	ads, word of mouth
8.	The department does not fund national searches and invests minimally in advertising. We are lucky to have an outstanding residency program that funnels great people into our group.
9.	diversity of job description
10.	Advertisements in major journals. Word-of-mouth.
11.	- print and online ads - word of mouth - recruiting booth at local conventions (eg ACP)
12.	advertising and word of mouth, but mainly recruiting among graduating house officers
13.	Word of mouth.
14.	There is no way to recruit outstanding hospitalists because the dept and section we are in

What methods are you using recruit outstanding hospitalists?

#	Response Text
	can't agree on what kind of hospitalist program we should be. There is so much waffling and changing of minds that we can't keep our ads straight let alone sell the job to anyone. We have decided that we would like to be an academic program but our superiors vascillate so often and don't provide any support. Our program is filled with foreign grads who need a visa sponsored and who would rather be in a fellowship program so their hearts are always divided. We can't recruit any of our own housestaff since we rarely are allowed to interact with them and they can see that the job we have is not very desirable.
15.	Opportunities to teach. Job description that is neither too hard nor too easy.
16.	Word of mouth is the biggest factor. Ads seem to have low yield.
17.	Trying to make base job sustainable, and looking for options for physicians to branch out as they gain clinical experience
18.	networking
19.	direct mailing to recent med school graduates direct recruitment from residency pool journal advertisemnts
20.	advertizing the position as a career with strong emphasis on professional development. We have strong hospitalist leadership.
21.	advertising and recruiting housestaff
22.	by creating a culture of teamwork, clinical and educational excellence and always advocating for sustainable positions (enhances success and minimizes burnout)
23.	word of mouth, contacts
24.	-word of mouth -local recruitments
25.	we're not - we're trying to recruit general internists who can see in-pts, out-pts, teach and maybe do something scholarly; there's a separate Hospital Medicine Division here.
26.	Create sustainable jobs
27.	-retention bonuses. -reduced work hours with seniority -agressive compensation-incentive plan
28.	Unique job description. “Off service” protected time for academic pursuits.

What are you doing to foster the academic promotion and growth of your hospitalists?

#	Response Text
1.	The relevant University will not promote clinician educators/hospitalists.
2.	In-house faculty development programs, development of formalized curriculum for reisdents and students in inpatient medicine, attendance at national meetings, development of workshops for regional and national meetings
3.	Provides 20% protected time. Have hired new hospital director with 80% protected time for research. Will recruit mix of clinician educators (20% research) and physician scientists (80% research). They will interact to assist each other. Physician scientists have large HSR Center for support.
4.	Encourage attendence to College of Medicine acadmic workshops for improving teaching skills, encouraging CME in excelellence in clinical skill.
5.	--protect a good deal of their time --connect them with coursework that would be helpful (e.g., mph) --connect them with faculty who can mentor them --have a weekly research in progress seminar for all division faculty --connect them with datasets and a data analyst, paid for by the division, to do secondary data analyses.
6.	it has been very difficult. Try to identify career objectives for young faculty then try to obtain protected time for them.
7.	promotion is not an issue, encourage academic growth
8.	I am encouraging them to get involved in whatever area interests them: QI, education, safety, etc. I can also give them a leg up by getting them in the door of many of the opportunities that exist.
9.	focused support and resources on selected individuals of the entire group
10.	We have our own internal academic activities (Academic Hospitalists Journal Club, Case

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#	Response Text
	Conference, Internal Physical Diagnosis Review Course, Education and Development Conference, Medical Education Journal Club). Each member is developing an area of clinical focus to allow scholarly activity. Probably of greatest importance is protecting the 12-16 weeks of academic diastole that each faculty member now has.
11.	- academic director's job is to encourage this - but otherwise not enough!
12.	dedicated mentors and faculty development program
13.	Protected time. Mentorship.
14.	protected time
15.	I have tried to get the department chair's consistent support but it has not worked. I have enlisted the assistance of other faculty outside of our section and department but everyone says that without our chair's support, it is not possible to foster any long term academic support.
16.	Clinical research seminar. Group projects. Mentorship.
17.	Guaranteed protected time, seed money for research and academic advancement.
18.	Developing an academic hospitalist group separate from the non-resident group.
19.	Not enough - they have so much clinical work they don't feel like they have time
20.	faculty development programs and other support that all faculty receive
21.	--mentored projects focusing on quality and safety --monthly junior faculty career development meetings --acknowledgement and evaluation of hospitalists contribution to process outcomes in our 2 hospitals --teaching skills curriculum --hospitalists participate in mentoring residents in a required Systems-Based-Practice Project (can be in-pt or out-pt but most res's choose in-pt)
22.	Same. Taking Quality/Service as an academic pursuit. Strong leadership to safeguard teaching time.
23.	creating GME opportunities sending to meeting like SGIM, SHM, MacMaster EBM course and sponsoring some to get MPH in mamangement and quality
24.	key clinical faculty in residency, educational leadership in residency and clerkships, medical directorships with hospital for wards and for a new EMR implementation;
25.	applications for internal funding for quality and patient safety studies, inclusion in quality and patient safety research group at our univeristy, supported fellowship training
26.	Projects in progress meetings (monthly) mentoring 1-on-1 start-up funds for investigator-initiatived projects shared resources (statistician)
27.	TBD
28.	Create sustainable jobs with diastole; built in. Create mentoring structure and support for academic activity.
29.	-teaching time -integration within residency
30.	Enrollment in University research mentorship program (1), ethics fellowship (1), masters of science in clinical research (2).