Hospitalist Well-Being
Maximize Engagement and Minimize Burnout for Hospitalists

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How Will This Module Help Me?

1. Identify drivers of hospitalist burnout in your hospital
2. Describe steps to help prevent burnout and improve wellness for hospitalists
3. Provide examples of successful hospitalist well-being programs in a variety of settings
Introduction

What Is Hospital Medicine?

Hospital medicine is the fastest growing medical specialty in the United States. The clinical focus of hospital medicine is caring for hospitalized patients. Although not all hospitalists are required to be internists, the nature of internal medicine training uniquely prepares internists for hospital medicine practice. As a result, the vast majority of hospitalists are trained in internal medicine, usually in general internal medicine. Hospital medicine grew out of the increasing complexity of patients requiring hospital care. By focusing their practice on this specific group of patients, hospitalists gain specialized knowledge in managing very ill patients and are able to provide high-quality, evidence-based, and efficient patient and family-centered care in hospital settings.

Most physicians who choose to go into hospital medicine have an interest in taking care of sicker patients and/or improving inpatient hospital systems. However, hospital medicine comes with a unique set of stressors. Hospitalists are responsible for 24/7 care of patients and have atypical work schedules that can encroach upon personal and family time. They may be exposed to pressures that are discordant with their patient care goals, such as throughput, RVU generation, or coding. The relative youth of hospital medicine as a field and of hospitalists themselves presents challenges as well.

Five STEPS to Promote Joy in the Practice of Hospital Medicine

1. Understand Burnout at Your Hospital
2. Minimize Burnout and Maximize Engagement
3. Promote Self-Care and Resilience
4. Communicate Frequently With Each Other and Across Specialties
5. Recognize and Reward

Understand Burnout at Your Hospital

Burnout is a common and serious issue faced by physicians today. Up to 55% of outpatient internal medicine physicians experience symptoms of burnout, with similar rates for hospital medicine physicians. Burnout is characterized by a sense of emotional exhaustion, depersonalization (cynicism towards your career or patients), and feelings of a diminished sense of accomplishment. While signs of burnout can be clear for some physicians, who make statements such as “I just don’t know how long I can do this”, it may be subtle for others, who might express thoughts such as, “That patient is so needy” or “Did you hear Dr Jones left clinical care altogether?”. It is important to recognize and assess the sources of burnout at your institution to create the most effective solutions.

Common causes of burnout include:
- Heavy workload and hours at work, which can lead to an invasion in personal life or increased isolation
• Administrative and EHR documentation, leading to spending the majority of the day on a computer, rather than directly interacting with patients, their families, and other health care providers
• Lack of autonomy and a disconnect with leadership, leading to feelings of a lack of respect or feeling like a cog in the wheel

Physicians who experience burnout are more likely to leave their practice and/or reduce their clinical hours.\(^5\) Burnout can lead to negative effects on patient care, such as medical errors, as well as poor interactions with colleagues.\(^6\)–\(^8\) More information on physician burnout in general can be found in the STEPS Forward™ Physician Burnout module. This module discusses the unique factors that can lead to burnout in hospitalists and details strategies to help hospitalists maintain joy in their practice.

**Drivers of burnout that are unique to hospitalists include:**

• Atypical schedules (shift work, nights, and weekends)
• Competing priorities from different stakeholders
• Relative youth and unique stressors of hospital medicine as a field
• Limited academic opportunities
• Pressure to care for patients outside your scope of practice

Because hospital medicine is a relatively new field, hospitalists may feel that they are not always understood or respected by patients, other specialists, outpatient physicians, or hospital leadership. Hospitalists frequently need to explain their role to patients; patients may not know why their outpatient physician may not see them while they are in the hospital. Additionally, communication and teamwork between inpatient and outpatient physicians is often limited. Hospital leadership may view hospitalists as staff who allow for outpatient physicians, subspecialists, and proceduralists to see more patients and generate more revenue, rather than a unique set of physicians with strengths of their own.

Another effect of the newness of the field is that opportunities for professional development for hospitalists can be limited. Hospital medicine mentors are far exceeded by the numbers of new hospitalists, and hospital medicine is often underrepresented in hospital leadership. When hospitalists take on leadership roles in community practices, they are often concurrently balancing large clinical loads. For academic hospitalists, research tends to center around health services outcomes, which does not directly correlate with the typical path to academic promotion, and time for furthering academic pursuits is often limited by demanding clinical schedules.

Each day, hospitalists must manage a variety of responsibilities, all of which have a different group of stakeholders—and all ideally should be done without delays. This can create a sense of misalignment of goals for hospitalists. Some examples include the need to:

• Prioritize the needs of sicker patients, discharging patients, and advancing the plan of care for others.
• Minimize the hospital length of stay while simultaneously working to prevent readmissions.
• Expedite patient discharges, while still being thorough. Many hospitals set goals to complete discharges at a particular time of day, typically before noon or 2 pm.

To assess burnout for hospitalists, conduct a needs assessment to determine where you are starting. For example, surveys on burnout, individual goals, and group goals are a great starting point. Surveys can be anonymous, and including an area for the addition of free text comments is helpful. In-person small group discussions can allow for deeper discussion. Needs assessments should be repeated yearly to track progress.

**Modified Pines Aronson Tedium Index Survey**

Use this tool to assess well-being among your team.

(MS WORD, 31 KB)
Q&A

What billing and coding challenges exist for hospitalists?

To capture the full scope of care that hospitalists provide, documentation requires a level of specificity that has become burdensome for many hospitalists. Documentation for billing and coding is a time-constraint, particularly when hospitalists are often required to revisit notes, which adds to the sense of extraneous administrative tasks. This issue has become so complex that many organizations have created physician and nurse supervisory roles specifically for the purpose of improving depth of billing and coding.

Hospitalist Documentation Tips
Use this tool as a quick reference guide for documentation tips.
(MS WORD, 38 KB)

2 Minimize Burnout and Maximize Engagement

Burnout and engagement are linked to three key concepts within the practice of hospital medicine: **autonomy**, **mastery**, and **purpose**.

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**Autonomy**

How much control do hospitalists have over their workload and schedule options? Do they have input into their compensation model (e.g., what proportion is based on quality metrics vs RVUs vs academic output)?

**Mastery**

Do hospitalists feel that their workload is manageable such that they can excel at it? Do they have control over their scope of practice?

**Purpose**

Is there a common vision and mission? Is there a mechanism in place for hospitalists to get support to achieve their goals?
Burnout is increased when one feels depleted in any of these areas, and engagement aims to cultivate all of these areas. Engagement comes from fostering a sense of community, cultivating academic excitement, providing professional development opportunities, minimizing exhaustion, and creating loyalty to the profession. It is important to recognize that opportunities for being active on the medical staff, in medical education, or in the community often occur during clinical hours when outpatient physicians would have canceled clinics or other protected time, but hospitalists often do not. Hospitalists do much of their work when other physicians and administrators are not in the hospital (evenings and weekends). Like other physicians, hospitalists need protected time to serve on hospital committees and in education and leadership; these duties should not be performed on days when they are not on service.

To combat burnout, more hospitalists are decreasing their hours and taking a cut in salary. These hospitalists use that unpaid time “off” to complete their nonclinical work without compromising patient care. While this is an effective strategy, it is not financially feasible for everyone to work a part-time schedule. For physicians who cut their hours to complete work responsibilities, the impact of a reduced salary will also be seen as burdensome. A hospitalist cutting their hours can also add to the burden of their colleagues who remain full-time.

Increasing Autonomy:
Autonomy in terms of scheduling can be a challenge given that the hospital is never fully closed. However, increasing hospitalists’ control over their schedules will improve recruiting, retention, and engagement. More and more hospitals are veering away from the traditional “7 days on, 7 days off” model and allowing the option of more days with fewer hours per shift based on personal preference. Schedules can include part-time options, late starts, early starts, swing shifts, and dedicated nocturnists. Shifts that are unpopular such as nights, holidays, back-up, and weekends should be paid at a higher rate (anywhere from 20% more to double).

Shorter blocks mean more days worked during the week; however, it allows the hospitalist to be home for dinner (and sometimes breakfast too) or to attend an evening family function. It can also be beneficial to be at the hospital more days—one can become more a part of the fabric of the hospital, which thereby creates a larger sense of community within the workplace.

Having per diem hospitalists can also help offset the pressure of filling an empty shift. Per diem hospitalists can be shared among several sites, which also affords more opportunities for the per diem hospitalist. Per diem hospitalists also provide an opportunity for a hospitalist retreat or activity where everyone can be present.

Cultivating Mastery and Purpose:

- **Committee work**
  Hospitalist participation in critical committee work (eg, quality, IT steering, pharmacy and therapeutics, length of stay, patient flow, patient experience), including committees with direct clinical consequences (eg, sepsis, heart failure, antibiotic stewardship, infection control), helps hospitalists become problem-solvers. Sometimes hospitalists can be deployed to leadership, communication skills, or management training through medical societies (Society of Hospital Medicine, American Association of Physician Leadership, American College of Physicians) to facilitate their entry into these roles. Participation in these committees should be recognized in performance evaluations.

- **Academic pursuits**
  Academic pursuits also cultivate a sense of mastery. Hospitalists should be encouraged to host journal clubs, present to their medical staff at Grand Rounds, or join and present at local medical society chapter meetings. An academic dashboard can be created to recognize and reward such efforts.

- **Geographic identity**
  Another solution lies within the concept of geographic identity: hospitalists can be encouraged to take ownership of the metrics of their unit. This must be coupled with the freedom to solve problems at the unit level and apply the skills of change management and leadership for both the nurse and hospitalist unit leaders. While an investment in training is needed, the rewards are not only a sense of autonomy and mastery, but improved efficiencies and team development—the hospitalist is not running around to many different units throughout the day but instead is working with the same team on the same unit, creating the same mental model of the plan of care for each patient each day.

- **Subspecialty expertise**
Finally, hospitalists could be given the opportunity to become an “expert” point-person for a specific subspecialty such as orthopedics or neurology, acting as a liaison between that department and the hospitalist group for other hospitalists. Ideally, they would receive financial support from that department and be integrated into department activities, and even attend subspecialist meetings both locally and nationally.

Addressing Inefficiencies

In conjunction with the three motivational areas outlined above, addressing inefficiencies in the daily environment is key to minimizing burnout and maximizing engagement. Most of the frustration among hospitalists comes from inefficiencies stemming from time spent on nonclinical work. Some potential solutions for this include:

- **Ensuring that all team members are working at the highest level of their licensure.** This includes medical assistant order entry and medication reconciliation, scribes, triaging of pages, and enhanced care protocols so that interprofessional team members such as nurses, pharmacists, social workers, and nutritionists have expanded responsibilities. Rounding with a “nurse attending” (a nurse who drafts discharge instructions, coordinates follow up, provides education, and anticipates patient discharge needs), pharmacist, or social worker can be a useful way to minimize inefficiencies.

- **Automating scheduling and load leveling tasks.** Several software platforms are commercially available that can automate most of the work needed to schedule shifts, handle shift changes/swaps, distribute patients evenly, and notify all key stakeholders of patient assignments.

- **Optimizing the EHR.** Periodic consultation with an EHR expert (hospitalist preferred, but can be a non-hospitalist) allows hospitalists to stay up to date on the best use of the EHR. This focus traditionally has been largely outpatient-based, but it is worthwhile to direct efforts to the inpatient side as well to improve hospitalist efficiency, reduce frustration, and potentially improve patient safety. This should ideally be done during usual work-hours, and geared toward reducing the total number of clicks through focused training on EHR efficiencies, including use of order sets and note templates.

- **Capturing non-billable RVUs.** Non-billable work for hospitalists is substantial. It is possible for hospitalists to enter “non-billable” RVUs and/or educational value units (EVUs) at the end of each shift the same way they do their true wRVUs, and this can be ultimately translated into compensation by the hospital. Examples may include attendance of interdisciplinary rounds, teaching of residents, preparing for or giving professional talks, or chart review. The menus of options for non-billable RVUs and their weighting can be determined by the hospitalists themselves (thereby also imparting a sense of autonomy). A downloadable quick reference guide is provided below.

- **Reducing documentation and coding queries.** Many hospitalists have received little training on documenting to capture the complexity of their patient care, and then receive queries from documentation and coding departments electronically to revise their notes. Providing training in best practices for documenting can improve billing and also reduce these requests. Furthermore, common coding queries can be used as a teaching tool for conferences (eg, a coding tip of the week). Coding cheat sheets (eg, on common diagnoses resulting in queries) can be given out for easy reference—see the downloadable tool provided below. Smartphrases that require completion of coding can be embedded into notes.

- **Tracking click counts and EHR use at home.** Displaying click counts through the EHR and EHR use at home (after hours) on the group’s dashboard can provide daily, visible data on EHR efficiencies and inefficiencies, and can help ensure that working to promote practice efficiency will remain a priority.

**Commonly Used Non-Billable RVUs**

Use this tool as a quick reference guide for non-billable RVUs.

(MS EXCEL, 21 KB)

**Hospitalist Documentation Tips**

Use this tool as a quick reference guide for coding.

(MS WORD, 38 KB)
What is the optimal work environment for hospitalists?

Hospitalists are often not supplied with the office space a professional would expect. As they are expected to be on the wards all the time, office space may be seen as an unnecessary luxury in a hospital strapped for space. However, it is very important for every hospitalist to have their own workspace or professional “home”. This makes hospitalists feel more comfortable and valued and increases productivity as well.

What is the optimal workload for hospitalists?

Critical to hospitalist engagement is managing workflow and schedules. Too high of a census can increase length of stay and cost, as well as increase hospitalist turnover. Creating a workload that allows for mastery such that hospitalists feel they provide good quality care is critical to satisfaction. The optimal census number depends on patient factors (patient complexity) as well as institutional factors (degree of localization, nursing, ancillary services, and APPs).

How can community and collegiality be improved?

Hospital medicine groups can foster a sense of community and collegiality by providing opportunities for hospitalists to spend time getting to know each other both inside and outside of work, such as through team meetings that include protected time for peer interaction, reflection on the work, and challenging cases. Consider having an “Inside Scoop” at the beginning of each meeting, where one hospitalist presents for 5 minutes on his or her life outside of medicine. Inviting colleagues from other departments to hospitalist group meetings and discussing interesting cases as well as shared concerns and opportunities can also promote collegiality.

How can hospitals help new hires feel valued?

Ensure onboarding is done deliberately including having progressive patient care duties and administrative responsibilities, as well as protected time for training in the EMR, that is geared toward the needs of hospitalists. New hires should be introduced to all members of the interdisciplinary team such as pharmacists, nurses, rehabilitation therapists, and discharge planners. Assigning one person to be a mentor can help new hires get quick answers for things such as commonly used phone extensions and EMR tips. Scheduling check-ins to see how new hires are faring can help identify challenges as well. A downloadable guide for hospitalist onboarding is provided under the Resources tab for reference.

What are unique aspects of pediatric hospital medicine that improve engagement and reduce burnout?

Over the last 10 years, pediatric hospital medicine has increasingly embraced family centered rounds. This is a model that involves planned, purposeful interactions and requires the permission of patients and families and the cooperation of physicians, nurses, and ancillary staff. These rounds help physicians see patients as more than the sum of illnesses, but as children with unique interests, backgrounds, and home environments. They also create a multidisciplinary team environment, allowing for engagement with colleagues. Family centered rounds promote patient and caregiver engagement, often helping bring purpose and job satisfaction to the physician as well as patients and their families. Models have been studied to help increase efficiency through family centered rounds. Suggestions have included having schedulers who can organize rounds and even give expected time “appointments” for families to be present or communicate through video technology. Pediatric hospitals often have Child Life Specialists, who plan events, such as parties and dances, which help bring joy to physicians and children alike.

While morbidity and mortality rates may be lower for pediatric patients, the death of a child, especially unexpectedly, can be very emotionally difficult for pediatric hospitalists, and contribute to burnout. Pediatric hospitalists often also care for children with suspected child abuse. Structured debriefing and counseling resources are essential to support staff. Pediatric hospitals also commonly hold Schwartz
Center Rounds, an interdisciplinary forum for staff and learners to discuss psychosocial and emotional aspects of care. These can be extremely helpful in processing socially challenging cases.

**Checklist for On-Boarding Hospitalists**
Use this tool to assist training and on-boarding hospitalists.
(MS WORD, 34 KB)

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### Promote Self-Care and Resilience

Resilience is the ability to bounce back after experiencing adversity. Many physicians are highly resilient people by nature, having completed rigorous training. Although most professional satisfaction depends on the work environment, part of the ability to enjoy work also depends on personal resilience.

Physicians build resilience by setting healthy limits, engaging deliberately with work, and cultivating mindfulness. Physicians are more resilient at work if they prioritize their personal health as well. This centers around what most of us know about wellness in general: avoid skipping meals, stay hydrated, have healthy snacks available at work, exercise, get enough sleep, and connect with friends and family outside of work. Many other examples of how to improve resilience can be found in the [Physician Well-Being STEPS Forward™ module](https://edhub.ama-assn.org/).

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**Q&A**

What factors of resilience are unique to hospitalists?

The drivers of hospitalist burnout described in Step 1 are also the factors that should be the focus of resilience. For example:

- Long hours can lead to musculoskeletal pain. Resilience can involve contacting an ergonomist on staff who can assess the workstation and make individualized recommendations.
- Night shifts can lead to insomnia and sleep disturbances. Resilience should focus on cultivating sleep hygiene and regular exercise.
- Complex patients can involve more serious events such as codes and deaths. Resilience should focus on how to deal with death and dying.

What are examples of ways to increase hospitalist resilience?

- Encourage gratitude: provide thank you notes for patients as well as staff, or post-it notes that can be placed upon a gratitude tree
- Promote mindfulness exercises and meditation
- Encourage reflective writing
- Host peer support groups such as interdisciplinary semi-structured discussions on emotionally challenging cases or semi-structured private discussion groups at restaurants and coffee shops outside of work. See the [Joy in Medicine STEPS Forward™ module](https://edhub.ama-assn.org/) for more information.
- Provide support or training on dealing with death and dying

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### Communicate Frequently With Each Other and Across Specialties

Communication is a major foundation of teamwork. High levels of teamwork have been associated not only with improved patient safety but also with stronger professional engagement and job satisfaction. In day-to-day work, interactions with others can determine whether physicians reflect on their day positively or negatively.
Similarly, social identity theory suggests that physicians naturally identify more with those within their own group and can view other specialties, support staff, or stakeholders as “other”. Good and frequent communication with stakeholders and colleagues can help improve collaboration and mitigate this tendency to categorize into “us” versus “them” buckets.

Reflect on an interaction you had when last on service. When you interact with a nurse or consultant, do you ask them about their day before making a request? Do you know them as a person beyond their role?

Q&A

How should communication up the ladder occur?

Site and system leaders can be too far removed from the day-to-day operations of a hospitalist to understand the requests for resources or appreciate daily challenges and successes. It is important to have hospitalist leaders present to their medical director (CMO) on a regular basis (monthly or at least quarterly). Hospital leaders can be invited to join hospitalists on rounds. This promotes collaboration and finding common goals among hospitalists and hospital leadership. Hospitalists can also run for positions on their hospital medical board. Where that option does not exist, they can request non-voting seats on the board.

How should communication across and down the ladder with other physicians and/or support staff occur?

Good communication can be accomplished via multiple forums: emails, newsletters, webpages, signs, meetings, or a combination of these. Whatever the forum, regular communication is a must. In general, emails should be kept brief, incorporating the highlights so that they are more likely to be read. Include more detailed information in an attachment or paste it below a brief summary of the information. Hold routine faculty meetings that are predictable in occurrence and discuss current issues within the group. Decrease surprises by communicating expected changes, including things “for your radar” on the emails.

Workgroups can be a great way to increase engagement and input into problem solving. Document group standards and expectations in guidelines or policies that are available to all (eg, inter-service agreements on consulting versus co-management). Consider having a repository of prior meeting minutes and newsletters, as well as an easy place to locate information on policies and previous decisions.

Getting your physicians together with “Lunch and Learns” can increase social connectedness and provide a nice change of pace in the day. Consider including other specialties to help build relationships.

Bimonthly digital newsletters to every hospitalist in the system serves to recognize accomplishments, generate a sense of community among geographically disparate sites, and deliver important news.

An annual academic summit with all hospitalists invited, leveraging per diems to free up the full-time faculty, is planned not only to generate academic excitement (eg, poster presentations, awards) but also to allow networking time for groups at different sites.

Social hours for new recruits as well as hospitalist leaders help develop a sense of community. Social and academic integration makes integration of business operations much easier as new hospitalists are brought on board.

Sample Co-Management Agreement Between Hospitalists and Another Service
Use this tool to foster collaborative relationships across the hospital.

(MS WORD, 52 KB)
Recognize and Reward

Developing and implementing a comprehensive reward and recognition program can promote collegiality and teamwork, plus provide an opportunity to demonstrate your hospital medicine group’s value to your organization. Building a culture of reward and recognition is inexpensive and high value.

During team meetings, consider encouraging hospitalists to share anecdotes about making challenging diagnoses or positive feedback from patients. Presenting service recognition awards (possibly with a small gift card as a token) is also a great way to reward hospitalists. Recognition awards can include:

- Hospitalist of the Month
- Service and Leadership Award
- Rising Star
- Compassion and Humanism Award
- Above and Beyond Award
- Excellence in Teaching

Subspecialists or primary care physicians can be similarly recognized and awarded (eg, “Most helpful consultant,” “Excellence in primary care”).

Invite hospital leadership to your team meetings when you recognize hospitalists, and send copies of letters of recognition to consultants, primary care physicians, and the hospital’s executive staff.

Collaborate with local, state, and national professional societies when considering other ways to recognize colleagues. State medical societies, the Society of Hospital Medicine, the American College of Physicians, and other organizations have robust awards programs.

Conclusion

Burnout among hospital medicine physicians is a fast-growing concern in this field. It is essential that hospitalist groups as well as hospital leadership recognize the major problem areas contributing to hospitalist burnout in order to offer effective solutions. Promoting autonomy, mastery, and purpose for hospitalists will increase the likelihood of long-term career stability and growth within the field.
AMA Pearls

- Perform ongoing assessments for burnout among hospital medicine physicians
- Encourage autonomy, mastery and a sense of purpose for hospitalists
- Maximize opportunities for communication and teamwork

Learning Objectives
1. Describe strategies to increase hospitalists' sense of autonomy and well-being
2. Identify opportunities for hospitalists to develop mastery and a sense of purpose

Article Information

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References