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Reviewing the Role of the GI Hospitalist in Modern Practice

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host Dr. Peter Buch, and joining me today to talk about the role of a GI hospitalist is Dr. Michelle Hughes. Dr. Hughes is an Assistant Professor of Medicine and Medical Chief of Quality and Safety at Yale School of Medicine who specializes in inpatient gastroenterology. She's also the lead author of *The Role of the Gastroenterology Hospitalist in Modern Practice*, which was published in *Gastroenterology* in 2020.

Dr. Hughes, thanks for joining us today.

Dr. Hughes:
Thank you so much for having me. It's a pleasure to talk about this growing role in the world of gastroenterology today.

Dr. Buch:
To start us off, Dr. Hughes, can you explain the role of a GI hospitalist?

Dr. Hughes:
That's a really great question and one I actually get quite a bit in my day-to-day. So I want to start by just kind of going all the way back to where hospitalists all started, and the movement really started about 25 years ago as a way to evolve to the changing healthcare climate. There's been a lot of increasing pressures related to managed care and the need for efficiency, and this role really came about as a way to adapt and evolve to these pressures. While it was initially described in internal medicine, it has really grown to include specialty and subspecialty providers as well, but not until recently has there been a growing number and, in fact, an increasing network of GI hospitalists. And GI hospitalists are fellowship-trained gastroenterologists whose role is really to be positioned in the hospital to provide rapid access to care. This means and translates to readily available for consults; they're on-site and eager to answer any questions that may come up from primary teams, they are ready and willing for procedures at any given time regardless of the emergency or emergent nature of it, there is close supervision of team members, and they, in fact, can also assist with operations and throughput because they are the most familiar with the inner workings of a system. And in some select systems they may also provide some primary services and primary patient care, though this is on the rarer side.

Dr. Buch:
And what are the benefits of a GI hospitalist program?

Dr. Hughes:
So the benefit of GI hospitalists really can be broken up into 3 categories or 3 buckets. The first is the benefit to the practice. By allowing providers to remain in their primary setting, they are able to stay in their clinics, in their scheduled endoscopy slots or in the hospital space, and this translates to increased productivity on all fronts. That means that there can be increased endoscopy volume, increased clinic capacity, and also improved consult volume as well, and this is because you're avoiding the unfortunate cancellations or

underutilized slots of ASCs of clinics, and underutilized hospital-based endoscopy slots. This also allows practices to avoid the backlogs that might happen when a provider has to cancel a day or a week at a time of their outpatient slots to accommodate for inpatient coverage.

The second bucket is the provider benefit. Just like practices, providers really feel the strain of having to balance and live in both worlds of both inpatient and outpatient, and so by allowing providers to remain either outpatient or strictly inpatient, you take away that need to balance or juggle the strains and daily demands of trying to manage an outpatient practice while you're covering the inpatient unpredictable volume, so this eliminates a significant amount of stress for providers.

The third bucket that benefits from a GI hospitalist is the system itself, and this is because the hospital system by allowing GI hospitalists in get a consistent liaison. This improves service access, practice, and hospital reputation, and also employs knowledgeable providers who are incredibly comfortable with the acutely ill patients that come day-to-day into the hospital. These providers or GI hospitalists are very familiar also with inpatient-specific guidelines. They are very comfortable with the inpatient endoscopy procedures that come along with these patients, including advanced hemostasis techniques, as well as other challenges, such as food impactions, volvulus management, or other challenging procedures. And they also know the resources to navigate the barriers more adeptly than somebody who only comes in and has to cover inpatient coverage for 1 to 2 months a year.

Dr. Buch:
And are there any challenges to consider when establishing such a program?

Dr. Hughes:
That's another really great question. You have to meet with key stakeholders, and they have to be supportive not only initially to create such a program but also really as continued support throughout the model's existence. That looks like allocating adequate resources. GI hospitalists certainly cannot be the solo fix to a dysfunctional system, and so resources must be allocated not only initially on the creation of a hospitalist model but also throughout in the months and years moving forward. You have to ensure support and equal citizenship to GI hospitalists as well. They, again, can't be the solo fix, but they also can get siloed in the hospital, and so you really want to ensure that they're incorporated into your practice and supported just like any other gastroenterologist or hepatologist in your practice.

It's important to reassess along the way as well. A successful launch of a GI hospitalist program may not be sustainable if you're not reassessing along the days, weeks, and months ahead because there will be barriers that you may not identify initially but may ultimately stand as a barrier to sustainability if they're not addressed. You have to also be proactive to ensure that you're not fragmenting care accidentally with your initiation of a GI hospitalist, and the way that you can address this is looking to transitional clinics and building really strong communication and handoff tools between your inpatient and outpatient providers to ensure that all of this information is not being lost. And one barrier that does come up is that patients do have to adjust to having an inpatient-only provider where they are used to previously having their outpatient providers come and care for them, and so it will also be important to ensure patient-facing messaging to really, really enforce that these providers are specialists in the inpatient care and that nothing is being lost between your inpatient and outpatient practitioners.

One other unique thing in academics in particular to consider is that your trainees will have a decreased exposure to different faculty supervising them. That's not necessarily a bad thing when you incorporate the fact that these inpatient GI hospitalists are very knowledgeable about guidelines, standard of care for inpatients, and also some of these advanced hemostasis techniques that other faculty may not know, but that you do have to be aware that they will have a more narrowed experience with opinions and practice patterns, so you do have to look to supplement that elsewhere.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Michelle Hughes about the role of a GI hospitalist.

So, Dr. Hughes, how would PAs, APRNs, medical students, and GI fellows fit into the GI hospitalist model?

Dr. Hughes:

Well, a team is absolutely essential to a successful GI hospitalist model, and so I would say that they all fit in as a welcome addition. For the trainees, particularly fellows, the residents as well, they really have this amazing opportunity to grow from an experienced inpatient provider, and so as an essential part of the team, they're providing consults and procedural support,, but in trade they're learning advanced hemostasis techniques, sort of the nuanced management of inpatient care from those that are most experienced in it, and they also get a boost of education as well because these providers are familiar with all of the conditions that they come into contact with every day.

The APPs, they develop a skillset on the inpatient and really live in the inpatient space in a realm that they can grow and foster, and so that's a really meaningful area for them to grow into and create this network within the hospital system of providers who they get to know, who they have phone numbers for, and who are easily able to communicate with for the care of their patients. They also, as part of a team, provide a very consistent knowledge of systems, workflows, and throughputs to ensure that care is efficient no matter who is rotating on or off the service, particularly in an academic setting where fellows may change from week to month. APPs also have a unique role in helping transition care not only between inpatient providers and inpatient teams in a multidisciplinary fashion, but also from inpatient to outpatient space, and so there is consideration of some models that help kind of improve the handoff of care by allowing the inpatient APPs to rotate in the outpatient space and follow some of those patients in a transition clinic or have outpatient colleagues who they can hand off to ensure that none of the important care features are lost in that handoff.

Dr. Buch:
Now if we focus on burnout for a moment, which is, of course, a major issue among all healthcare professionals, what strategies can help prevent burnout in GI hospitalists?

Dr. Hughes:
Ahh, well as we know, burnout in healthcare in general is a really ongoing hot topic, and there are some unique considerations to GI hospitalists that may exist a little bit differently than the rest of gastroenterology. I think that inpatient space is a bit different in that one unique thing about being a GI hospitalist is that there is a very significant variability between the volume of patients you're seeing every day and potentially also the hours of the day that you're working, and so when looking at a GI hospitalist model, if you're considering it as a career or building it into your practice, you have to be cognizant to build a system to protect and to support the GI hospitalist to ensure that that unpredictability doesn't really wear on them and create burnout and ultimately prevent sustainability of the role.

It's also very important to ensure that you have adequate reimbursement. Because the volume that they see is very unpredictable; basing a salary on things like RVU or work RVUs is really a big stressor because you cannot recruit patients, you cannot change the volume that you may see a day, and so, having a financial concern on top of this unpredictable nature of other parts of their job can be overwhelming, and so it's likely more successful to have a salary-based or incentive-based on some other feature to ensure that the financial concerns aren't also contributing to burnout in the GI hospitalist.

This overall really is an evolving role across the country, and so the resources and support really are still being defined for this role, and so understanding that there is some flexibility that is needed and that the needs of the model today may look different than a year or two from now is really important, and so revisiting and having that structured ability to revisit those issues will be important, again, to help reduce some of that burnout and uncertainty that comes with really every aspect of the GI hospitalist.

Dr. Buch:
Well, that's all the time we have for today. But with those final thoughts in mind, I want to thank my guest, Dr. Michelle Hughes, for a great discussion and for sharing her insights on the role of a GI hospitalist. Dr. Hughes, it was a pleasure having you on the program.

Dr. Hughes:
Thank you so much. It was wonderful to talk with you today, and I thank our listeners for tuning in as well.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GI-Insights where you can Be Part of the Knowledge. Thanks for listening.