ABSTRACT. Pediatric hospitalist programs have become increasingly popular recently, emulating the growth and success of adult hospitalist programs. This statement provides an overview of hospitalist programs, factors influencing their growth, and their expected benefits. Six guiding principles for the establishment of pediatric hospitalist programs are identified in this statement concerning voluntary referrals; local design; minimum physician-training requirements; arrangement for appropriate follow-up; communication among primary care physicians, subspecialists, and hospitalists; and data collection and outcome measurements. Pediatrics 2005; 115:1101–1102; hospital medicine, hospitalist, inpatient care.

BACKGROUND

Over the last 10 to 15 years, hospital-based physician programs have evolved in many communities to meet the changing demands of work in outpatient and inpatient settings. Wachter and Goldman1 coined the term “hospitalist” in 1996 to identify physicians, typically internists, family practitioners, or pediatricians, who concentrate their professional activities on the care of hospitalized patients (inpatients) as opposed to ambulatory patients (outpatients). Specifically, they defined hospitalists as physicians who spend more than 25% of their time based in a hospital setting, where they serve as physicians of record after accepting hand-offs of hospitalized patients (inpatients) as opposed to ambulatory patients (outpatients). More recently, the Society of Hospital Medicine (formerly the National Association of Inpatient Physicians) has defined hospitalists as “physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching research, and leadership related to hospital care.”2 This commitment to inpatient practice provides extended on-site attending-physician availability, clinical experience and expertise in the management of hospitalized patients, and a commitment to improve systems of care within the hospital setting. Wachter and Goldman1 hypothesized that these factors would ultimately lead to an overall improvement in the quality and value of care delivered.

Specialization in inpatient care existed in various forms in many communities long before the emergence of the term “hospitalist.” With the advent of managed care and its associated economic pressures, hospitalist programs have increased in prevalence. Other factors influencing the growth of the hospitalist model include the increased complexity and disease severity of hospitalized patients, decreased numbers of admissions for many office-based practitioners, the need for alternate in-house coverage with decreases in community hospital residency programs, the desire of many physicians to focus on ambulatory medicine, physician quality-of-life issues, and quality-of-patient-care issues. More recently, the successful and published track records of existing programs have convinced other communities and institutions to pursue hospitalist programs. Many “traditional” teaching services that previously used rotating subspecialists or office-based generalists 1 or 2 months per year as teaching attending physicians are now incorporating full-time hospitalists as dedicated attending pediatricians for patient-management oversight and resident teaching roles.3

Adult hospitalist programs have been well studied and demonstrated to provide high-quality outcomes with decreased average lengths of stay and decreased costs while maintaining both patient and referring-physician satisfaction.4,5 Emerging pediatric hospitalist data reflect similar results.6–8

Hospitalists are well positioned to play active roles in addressing system issues through quality improvement initiatives within the hospital, because that is their primary work environment. Communications systems have been well established to provide for consistent and continuous care when the patient is initially referred from the primary care and/or subspecialty physician to the hospitalist on admission and again at discharge when the patient is referred back to the primary care and subspecialty physician(s) for follow-up care. Such coordination is critical to preserve continuity of care within the child’s medical home. This is a founding principle for the success of adult hospitalist programs: communication among physicians needs to be timely and complete with interim reports of important hospital events and appropriate arrangements for follow-up.9,10 A second fundamental principle of adult hospitalist programs endorsed by the American Medical Association,11,12 Society of Hospital Medicine,13 and American Academy of Family Physicians14 is that hospitalist programs should be voluntary. Physicians
should not be mandated to refer patients to hospitalist programs and should retain the right to function as attending physicians for their own patients.

In pediatrics, the range of individual practice designs is large. Hospitalist programs have been developed to meet the needs of individual communities and institutions. Thus, the clinical responsibilities of pediatric hospitalists vary significantly. Some pediatric hospitalists practice exclusively on general inpatient wards of tertiary care academic children’s hospitals. Others work in community hospitals with small pediatric inpatient units and are responsible for general inpatient care as well as pediatric emergency department consultations, pediatric attendance at deliveries, and/or newborn care. Still others may include work with subspecialists and intensivists and/or neonatologists to assist in the care of hospitalized subspecialty or critically ill children and newborns. Despite these variations in scope of clinical practice, a uniform set of guiding principles for pediatric hospitalist programs similar to that for adult hospitalist care can be identified.

RECOMMENDATIONS

The following basic principles are recommended for pediatric hospitalist programs:

1. All pediatric hospitalist programs should be based on voluntary referrals. Pediatricians and other qualified primary (or specialty) care physicians should always retain the option to admit and manage their own patients. They should also retain the privilege to accept and participate in unassigned patient admissions at their desire or discretion.

2. Each pediatric hospitalist program should be designed to meet the unique needs of the patients, families, and physicians in the community it serves.

3. Physicians serving as hospitalists should be board certified in pediatrics or have equivalent qualifications.

4. Pediatric hospitalist programs should include in their design provision for appropriate outpatient follow-up of patients on discharge.

5. Pediatric hospitalist programs should provide for timely and complete communication between the hospitalist and the physicians responsible for a patient’s outpatient management, including the primary care physician and all involved subspecialists.

6. Pediatric hospitalist programs should include data-collection and outcome-assessment capabilities to monitor their performance and are encouraged to contribute to research studies involving the care of hospitalized children.

REFERENCES


All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.
Guiding Principles for Pediatric Hospitalist Programs

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