Building Effective HM Teams

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Faculty Disclosure

No relevant financial relationships to disclose.

Educational Need/Practice Gap

- Hospital medicine remains among the specialties with the highest burnout rates; SHM 2026 Workforce Experience Report: **41.4% of physicians meet burnout criteria, only 26.6% meet professional fulfillment criteria** - improved from 2024 (45.2% / 24.6%), but nearly half the field remains burned out

- The gap: programs respond with initiatives aimed at the top of the pyramid (wellness committees, recognition programs, leadership retreats) while foundational layers (staffing, predictability, equity) remain unaddressed

- What's missing is not effort but sequence: a framework for what to build first in order to build healthy and high functioning teams

Objectives

Upon completion of this activity, participants will be able to:

1. **Identify** the foundational needs of effective hospitalist teams.

2. **Analyze** how team systems and relationships influence culture and professional fulfillment.

3. **Evaluate** a hospital medicine program using a needs-based framework.

Expected Outcome

- What is the desired change/result in practice resulting from this educational intervention?

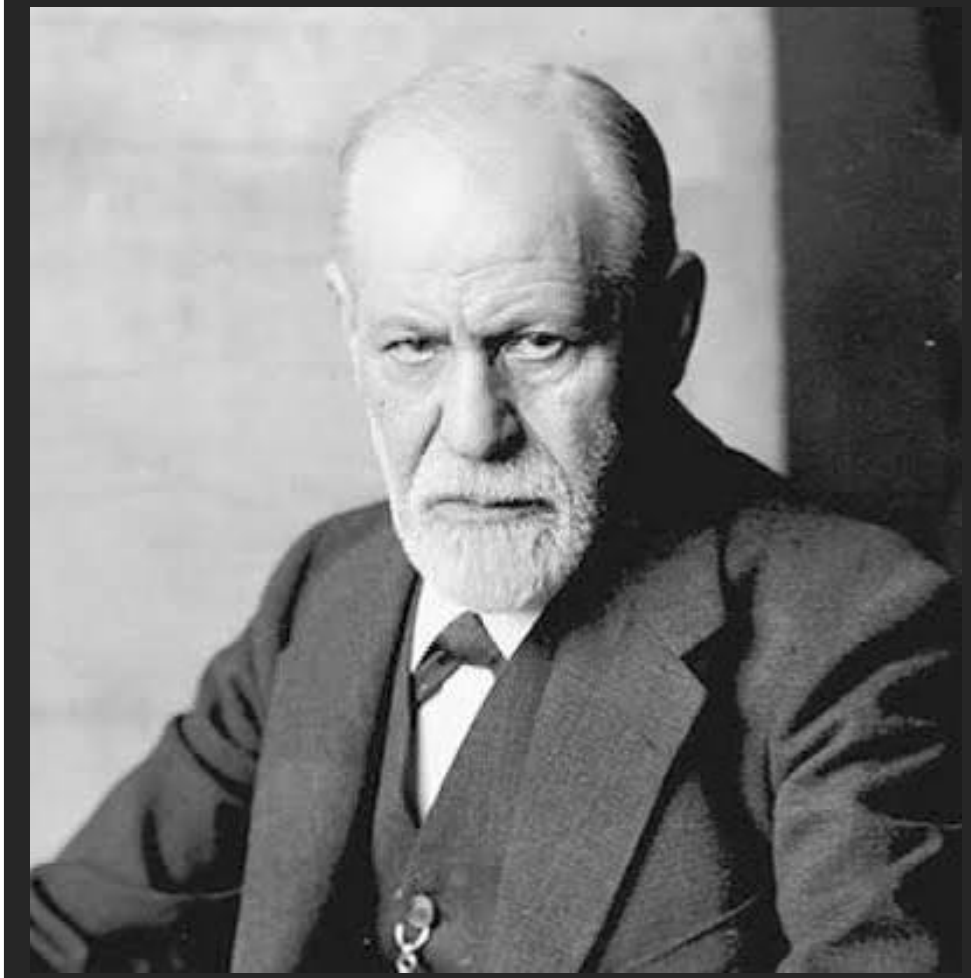
PSYCH 101


Self-Actualization
becoming the most one can be
Esteem
respect, recognition, status
Love and Belonging
friendship, family, connection
Safety Needs
personal security, employment, resources, stability
Physiological Needs
air, water, food, shelter, sleep, health

Abraham Maslow

- American psychologist (1908–1970); professor at Brooklyn College and later Brandeis University

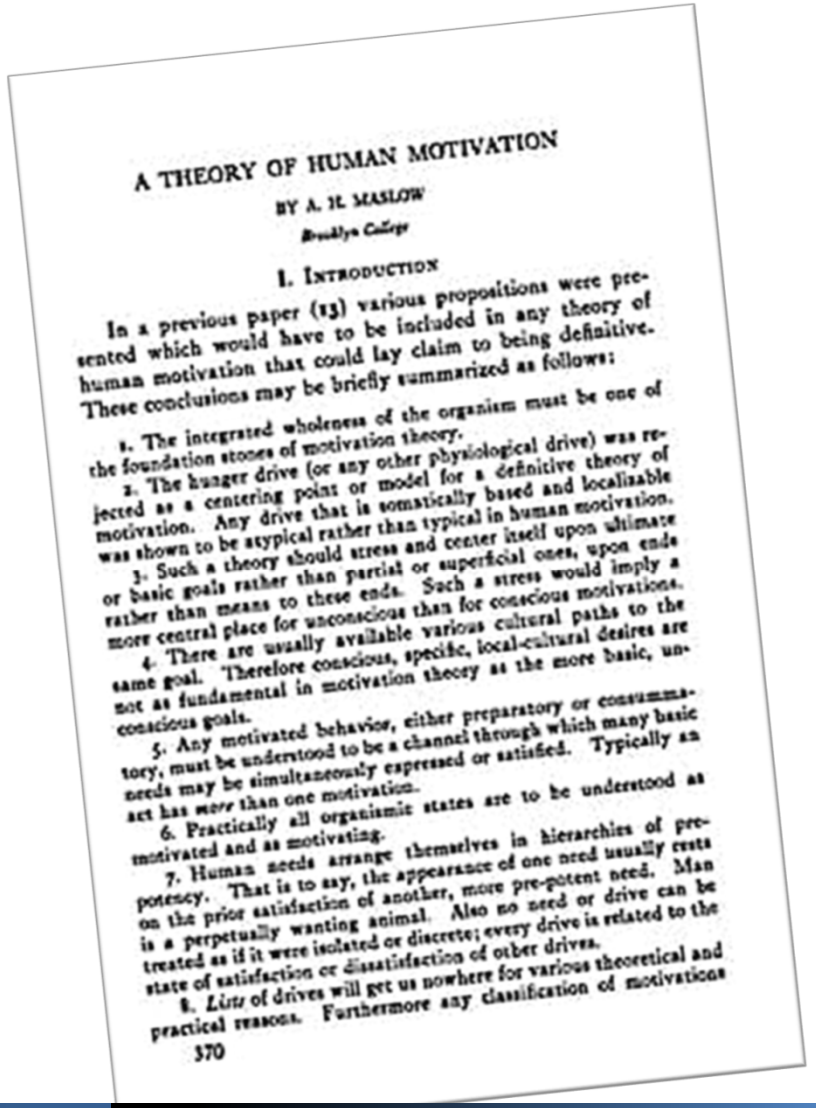
- His novel move: instead of studying what's wrong with people, he studied what makes people flourish



- Introduced in his 1943 paper *"A Theory of Human Motivation"* (Psychological Review), expanded in his 1954 book *Motivation and Personality*

- Core claim: human needs are organized in a rough order of priority: physiological → safety → love/belonging → esteem → self-actualization

- Lower needs are "prepotent": when unmet, they dominate motivation and crowd out everything above



A THEORY OF HUMAN MOTIVATION

BY A. H. MASLOW

Brooklyn College

I. INTRODUCTION

In a previous paper (13) various propositions were presented which would have to be included in any theory of human motivation that could lay claim to being definitive. These conclusions may be briefly summarized as follows:

1. The integrated wholeness of the organism must be one of the foundation stones of motivation theory.

2. The hunger drive (or any other physiological drive) was rejected as a centering point or model for a definitive theory of motivation. Any drive that is somatically based and localizable was shown to be atypical rather than typical in human motivation.

3. Such a theory should stress and center itself upon ultimate or basic goals rather than partial or superficial ones, upon ends rather than means to these ends. Such a stress would imply a more central place for unconscious than for conscious motivations.

4. There are usually available various cultural paths to the same goal. Therefore conscious, specific, local-cultural desires are not as fundamental in motivation theory as the more basic, unconscious goals.

5. Any motivated behavior, either preparatory or consummatory, must be understood to be a channel through which many basic needs may be simultaneously expressed or satisfied. Typically an act has *more* than one motivation.

6. Practically all organismic states are to be understood as motivated and as motivating.

7. Human needs arrange themselves in hierarchies of prepotency. That is to say, the appearance of one need usually rests on the prior satisfaction of another, more pre-potent need. Man is a perpetually wanting animal. Also no need or drive can be treated as if it were isolated or discrete; every drive is related to the state of satisfaction or dissatisfaction of other drives.

8. *Lists* of drives will get us nowhere for various theoretical and practical reasons. Furthermore any classification of motivations

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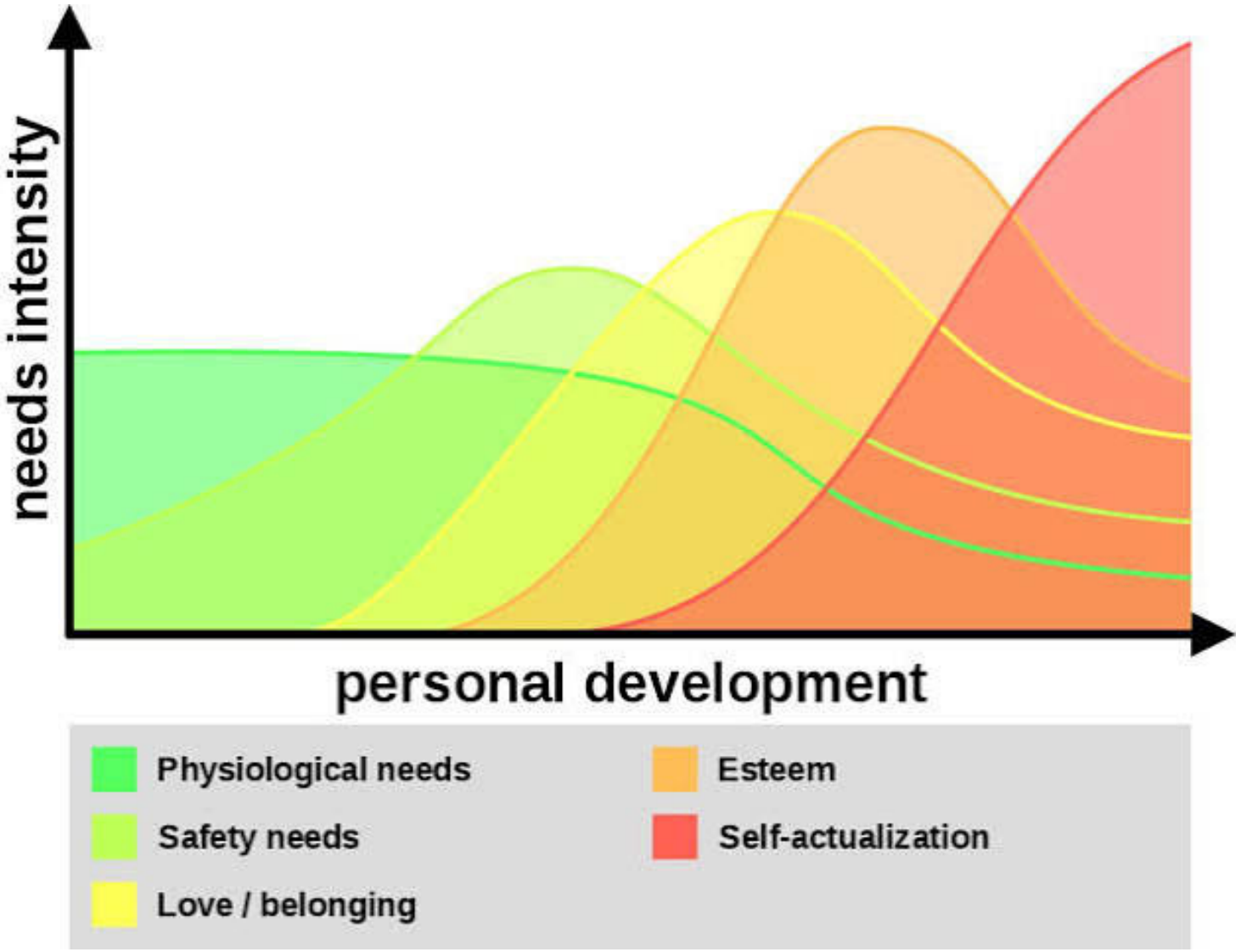
Physiological - The body's baseline requirements: food, water, sleep, shelter. Nothing else matters when these are unmet.

Safety - Security and stability: physical safety, employment, health, resources, freedom from fear.

Love & Belonging - Connection: friendship, family, intimacy, feeling part of a group.

Esteem - Respect and recognition: self-esteem, status, being valued by others for what you contribute.

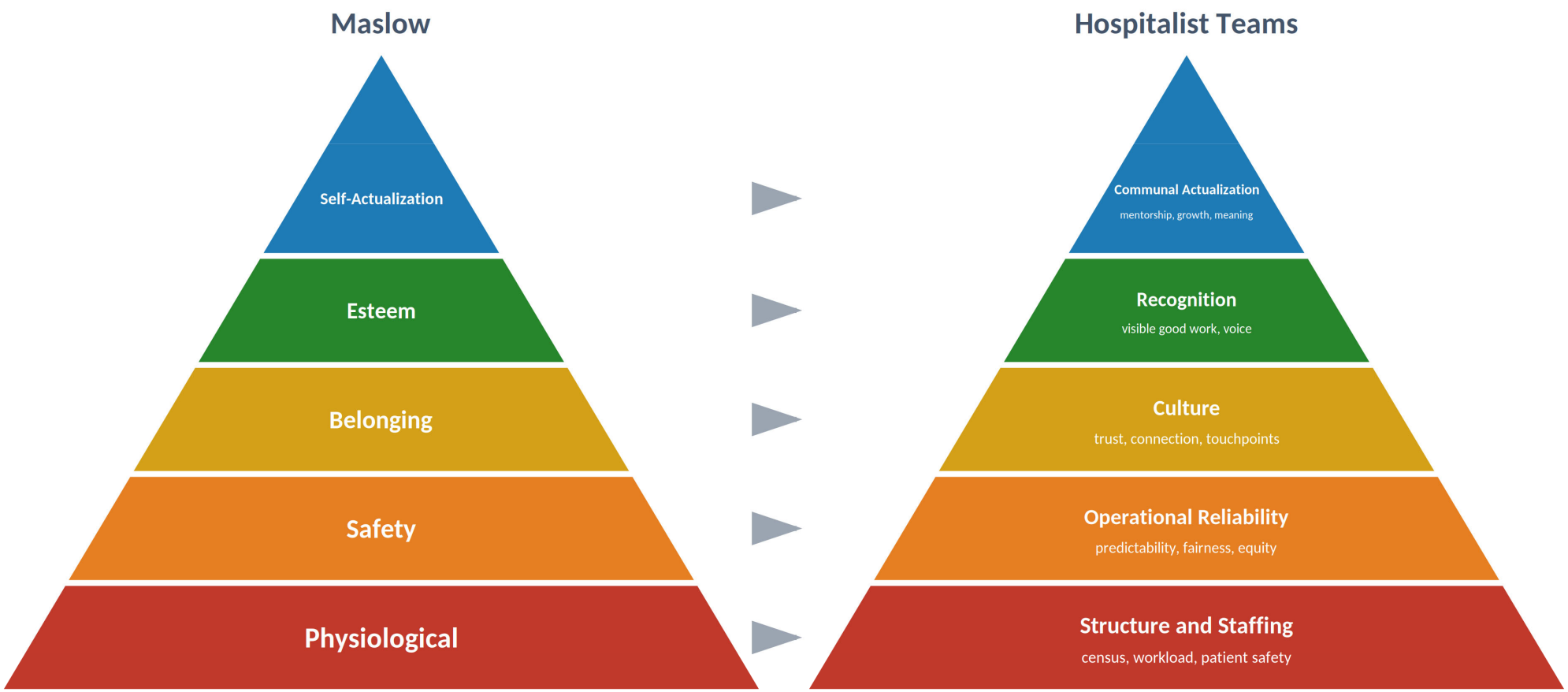
Self-Actualization - Becoming the most that one can be: growth, purpose, realizing your full potential.


needs intensity
personal development
Physiological needs
Safety needs
Love / belonging
Esteem
Self-actualization

Key Takeaways

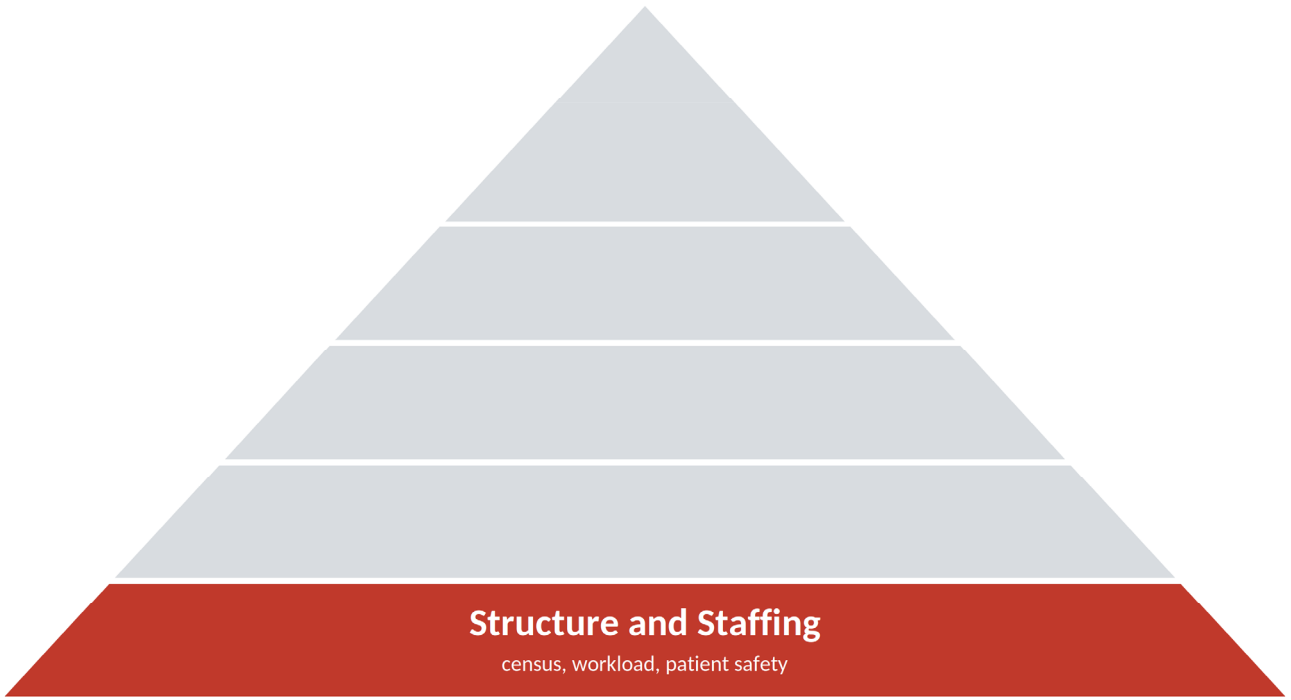
- **Sequence matters:** unmet lower needs dominate attention; a person worried about safety can't focus on esteem or growth
- **You can't skip levels:** higher-level aspirations are likely to fail when the foundation is unmet
- **It's a framework, not a law:** Maslow himself acknowledged the order isn't rigid and people move fluidly between levels

From Maslow to the Hospitalist Team



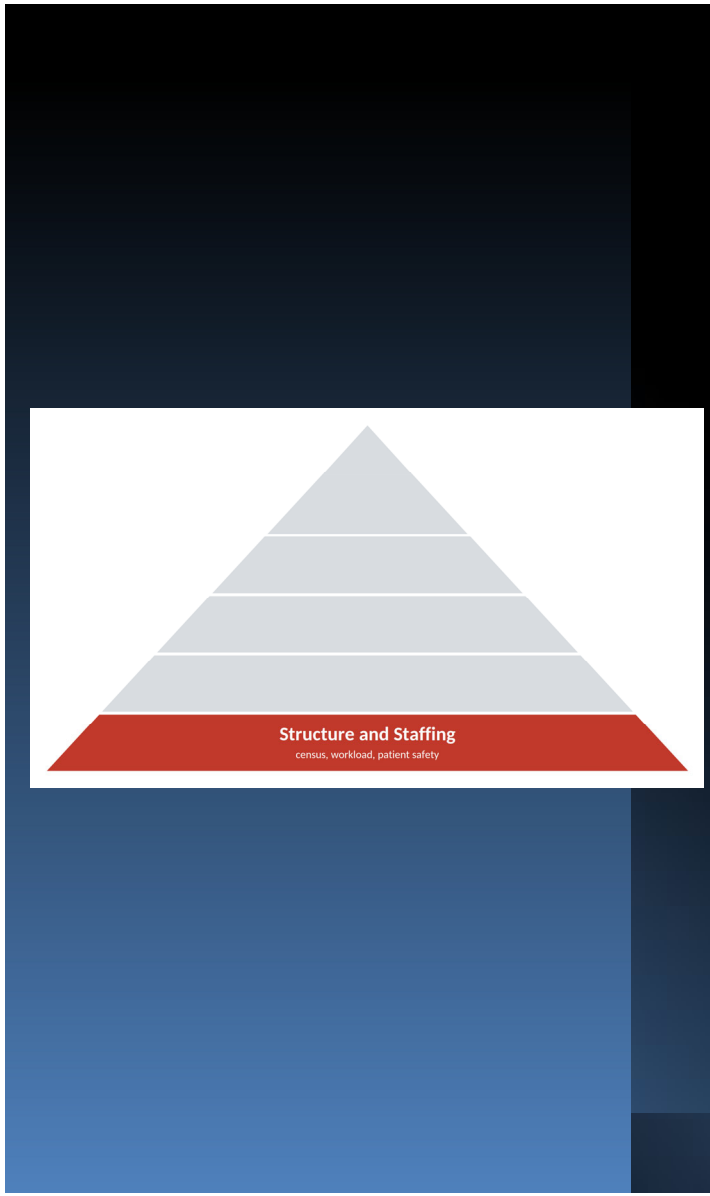

Communal Actualization
mentorship, growth, meaning
Recognition
visible good work, voice
Culture
trust, connection, touchpoints
Operational Reliability
predictability, fairness, equity
Structure and Staffing
census, workload, patient safety

II. Physiologic Needs → Structure, Staffing, & Safety



Basic Survival Needs

Just as Maslow's physiological needs are the non-negotiable foundation, hospitalist teams have baseline structural needs (staffing, workload, patient safety) that must be met before culture and performance can be optimally addressed



Addressing Basic Needs

Team Structure and Workload

Staffing and Recruiting

Workplace Safety

shm
Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

Hospital Medicine Workforce Experience Report

Summer 2026

Productivity = PPH

Figure 2.0
Average Physician Patient Census
for Typical, Daytime Shifts

Patient Type	Patients Per Shift*	Patients Per Hour
Adults (n = 626)	15.5	1.4
Children (n = 103)	14.1	1.3

Employment Model	Patients Per Shift*	Patients Per Hour
Hospital, health system or integrated delivery system (n = 404)	15.6	1.4
Private local/regional hospitalist-only medical group (n = 35)	18.3	1.8
Multistate hospitalist management company (n = 46)	18.4	1.5
Private multispecialty or primary care medical group (n = 9)	17.3	1.4
University, medical school, or faculty practice plan (n = 178)	13.5	1.2
Veterans Administration (VA) hospital (n = 12)	11.9	1.2

Productivity vs clinician and patient safety

Figure 2.1
Average Number of Patients for Physicians during Typical, Daytime Shift and Agreement with "My patient census felt safe for patient care."
n = 694

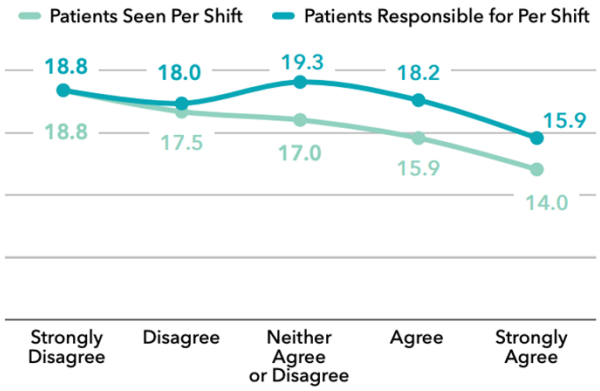
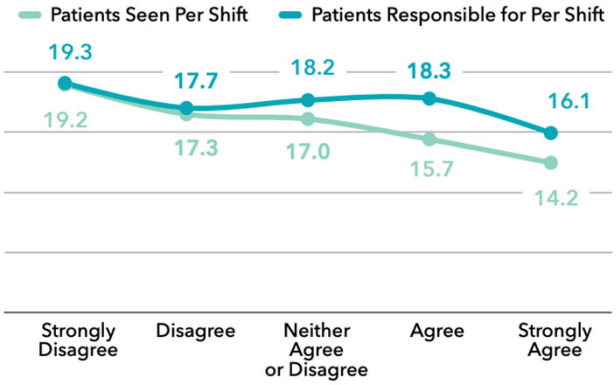


Figure 2.2
Average Number of Patients for Physicians During Typical, Daytime Shift and Agreement with "My patient census felt safe for me as the clinician."
n = 684



Nocturnist Productivity

9.5 patients = PPH of 0.79 (n=76)

Avg cross coverage = 63.2

Unbillable work = difficulty capturing productivity

Monitoring

How we build shift maps matters; much of physician satisfaction, quality, patients outcomes, and culture are all downstream

Productivity should be constantly monitored and structure adjusted to reflect sustained shifts in volume

Recruiting & Selection:
The Right Clinician for the Right Facility

- Recruiting failures are usually framed as "we hired a bad clinician." Far more often, the truth is "we hired a good clinician into the wrong facility"
- Screening asks: *is this person good?* Matching asks: *is this person good for this place?* Those are different questions, and most recruiting processes only ask the first one
- A mismatch doesn't just create culture friction later - it becomes a staffing problem: early turnover, coverage gaps, locums dependence, and a restarted recruitment cycle that costs the group a year. That's why selection lives in the foundation layer

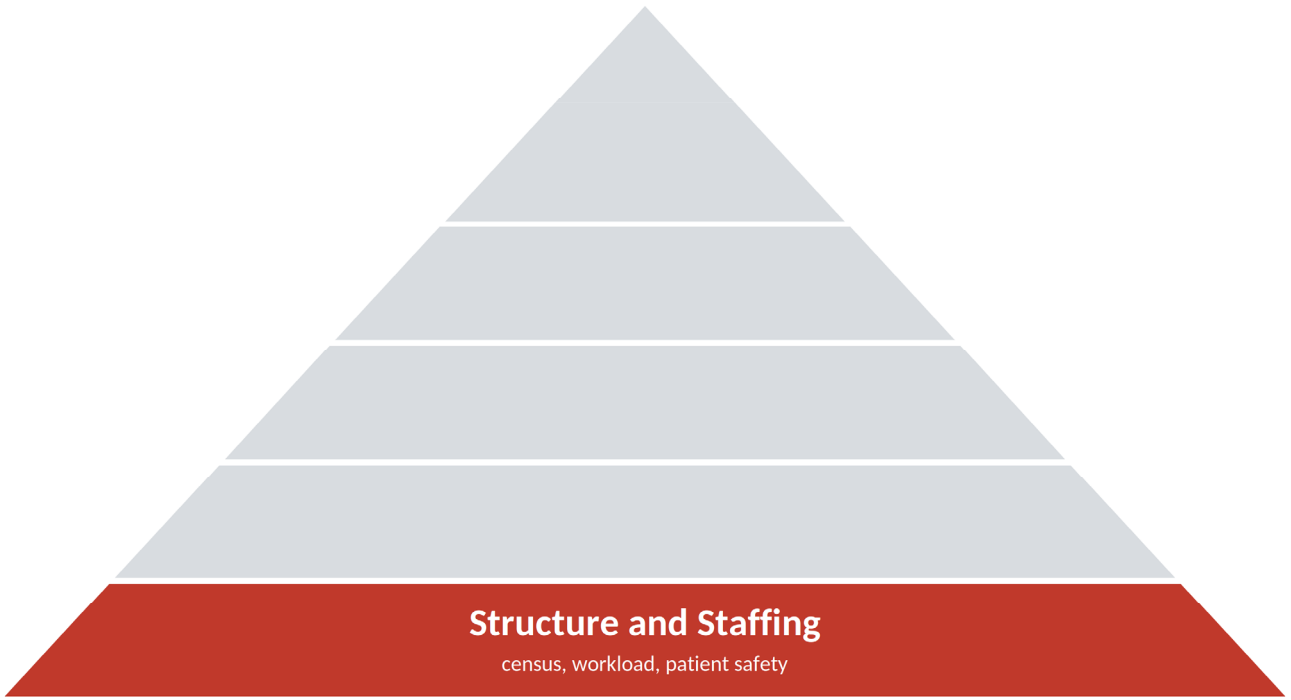
- **Acuity and scope**: open vs. closed ICU, procedures expected or not, code blue/RR, what the hospitalist covers at 2am. A clinician who thrives with subspecialty backup one call away may drown where they *are* the backup
- **Resource environment**: consultant availability, nursing experience, case management depth, transfer options. The 2026 SHM data backs this: hospitalists name consultant availability and nursing quality among the top enablers of best patient care
- **Practice rhythm**: 12-hour 7-on/7-off vs. Monday-Friday with weekend coverage; census expectations
- **Teaching vs. non-teaching**: some clinicians need learners to feel professionally alive; others experience them as friction
- **Community context**: rural/critical access vs. community vs. tertiary/quaternary; whether the clinician wants to *live* in that community or commute-and-escape (which predicts longevity better than almost anything on the CV)

Workplace Violence (Literal Safety)

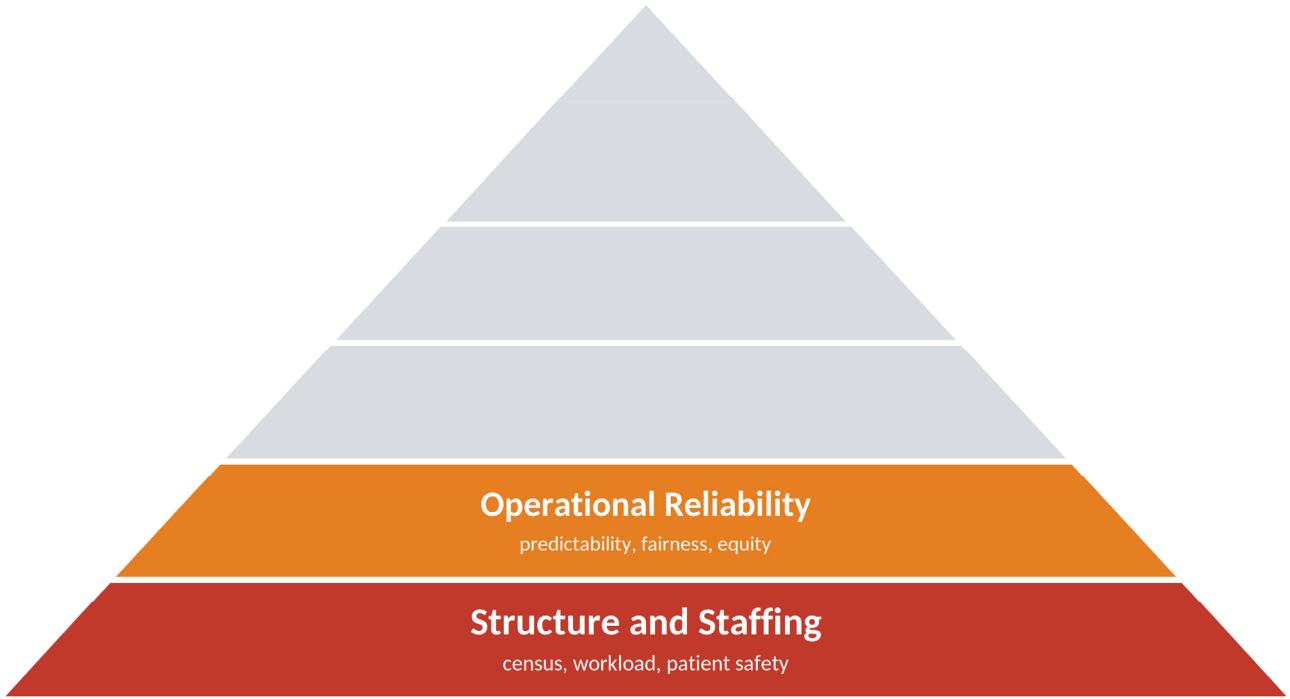
Workplace Violence

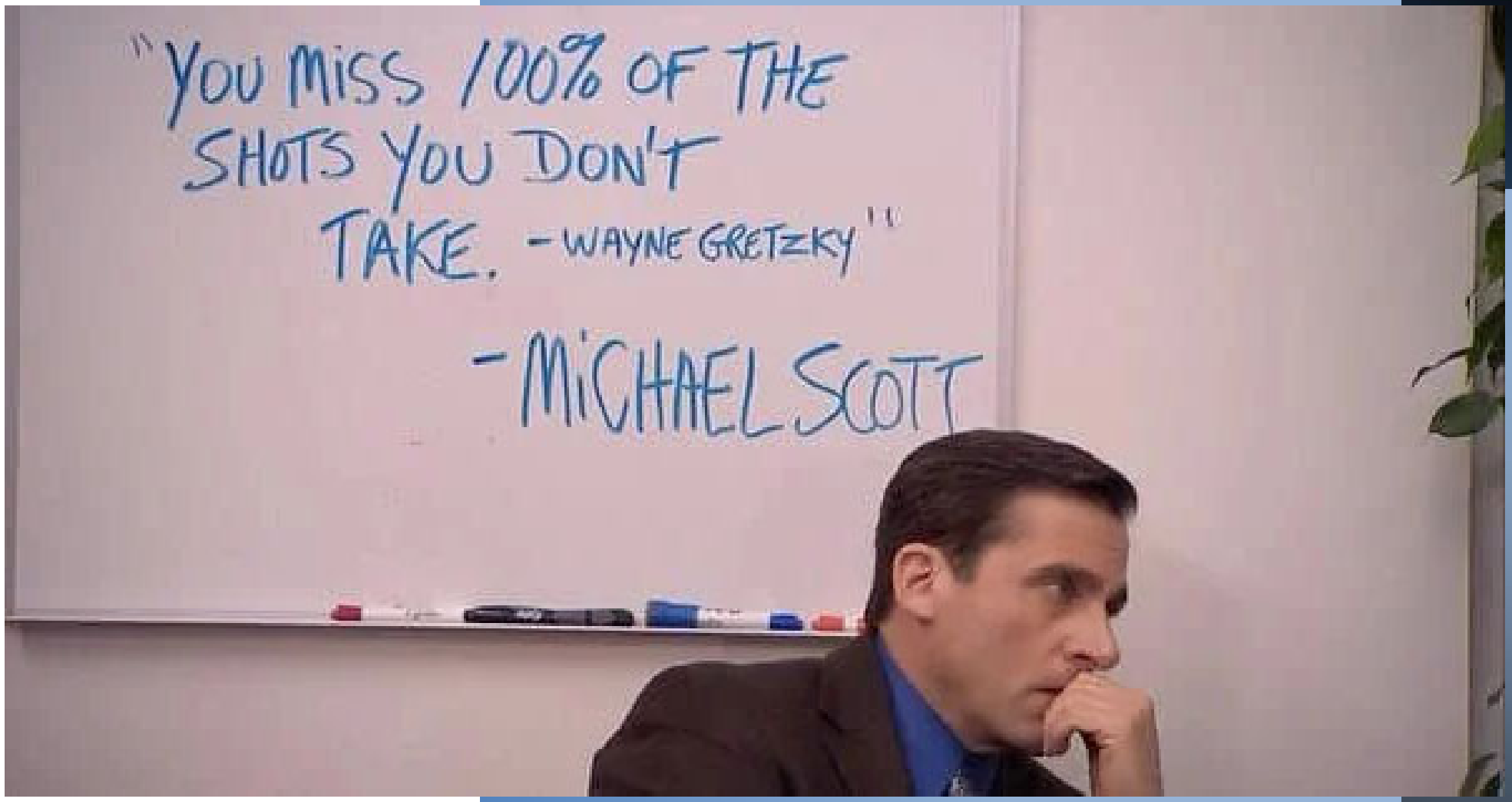
- 30.0% of clinicians experienced workplace violence in the last 12 months (28.9% of physicians, 41.5% of NPs, 34.3% of PAs)
- The well-being cost: burnout is nearly 20 points higher among those who experienced violence (54.7% vs. 36.0%), and for those who wanted support after an event but did not receive it, burnout reached 64.5%
- Mitigation matters: 44.3% of physicians at institutions using no mitigation strategies experienced violence, vs. 26.9% where strategies exist. Prevention infrastructure (response teams, risk assessment, de-escalation training, panic buttons) is measurably protective.
- A hospitalist who does not feel physically safe on shift cannot be asked to invest in culture, recognition, or growth. This is the most literal meaning of practicing safely.

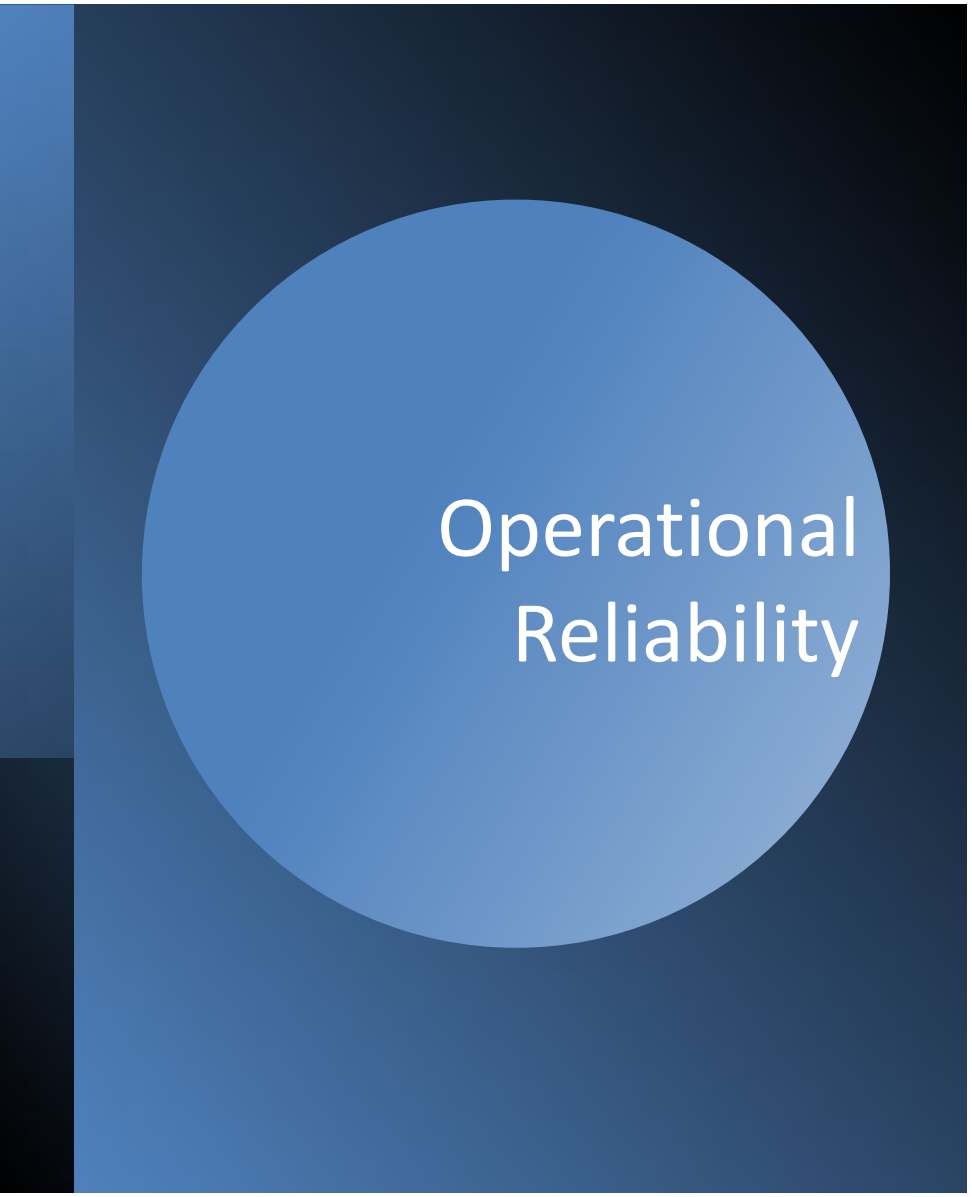
I. Physiologic Needs → Structure, Staffing, & Safety



II. Operational Reliability




"YOU MISS 100% OF THE
SHOTS YOU DON'T
TAKE. - WAYNE GRETZKY"
- MICHAEL SCOTT



"Good hospital medicine practice has always been about reducing unpredictability in an inherently unpredictable environment."

Operational Reliability

Schedule Stability and Predictability

Fairness and Equity

Reliable Systems for Volume variability

Structured Communication and Leadership


When dealing with doctors, what are the 2 things you don’t mess with?

Scheduling

- Long-horizon scheduling as a deliberate program investment: the single most visible proof that leadership values clinicians' lives outside the hospital
- Concrete benchmark: schedules published at least 90 days in advance (often the full year out in HM)
- SHM 2026 autonomy data backs this layer directly: hospitalists ranked schedule as the #2 factor most important to their sense of autonomy (after daily clinical workflow), and feelings of control/autonomy strongly track with fulfillment and burnout (75.6% of physicians who lack a sense of autonomy meet burnout criteria vs. 32.5% of those who have it)
- Written, transparent rules for holiday/weekend distribution and time-off requests. An arbitrary system reads as unfair even without bad intent; the absence of predictabilitv is itself the problem

Fairness and Equity

- Fair and equitable division of nights, weekends, and holidays - not concentrated on whoever's least able to push back (junior faculty, newer hires, APCs)
- A real, transparent pathway for time-off requests around family and personal events
- Elimination of preferential treatment - perceived favoritism erodes trust fast
- Equitable pay - parity across similarly-situated roles as a structural signal of whose contribution the system values

Reliable Structure for Volume Surge or Clinician Illness

- A real escalation path - someone who will actually show up when needed, not just a policy that says one exists
- Same backup response every time, regardless of who's asking — that consistency is what makes it trustworthy
- Systems with census control (fixed caps, backup staffing plans) had lower rates of self-reported unsafe workload (Michtalik 2013)

Structured Group Communication

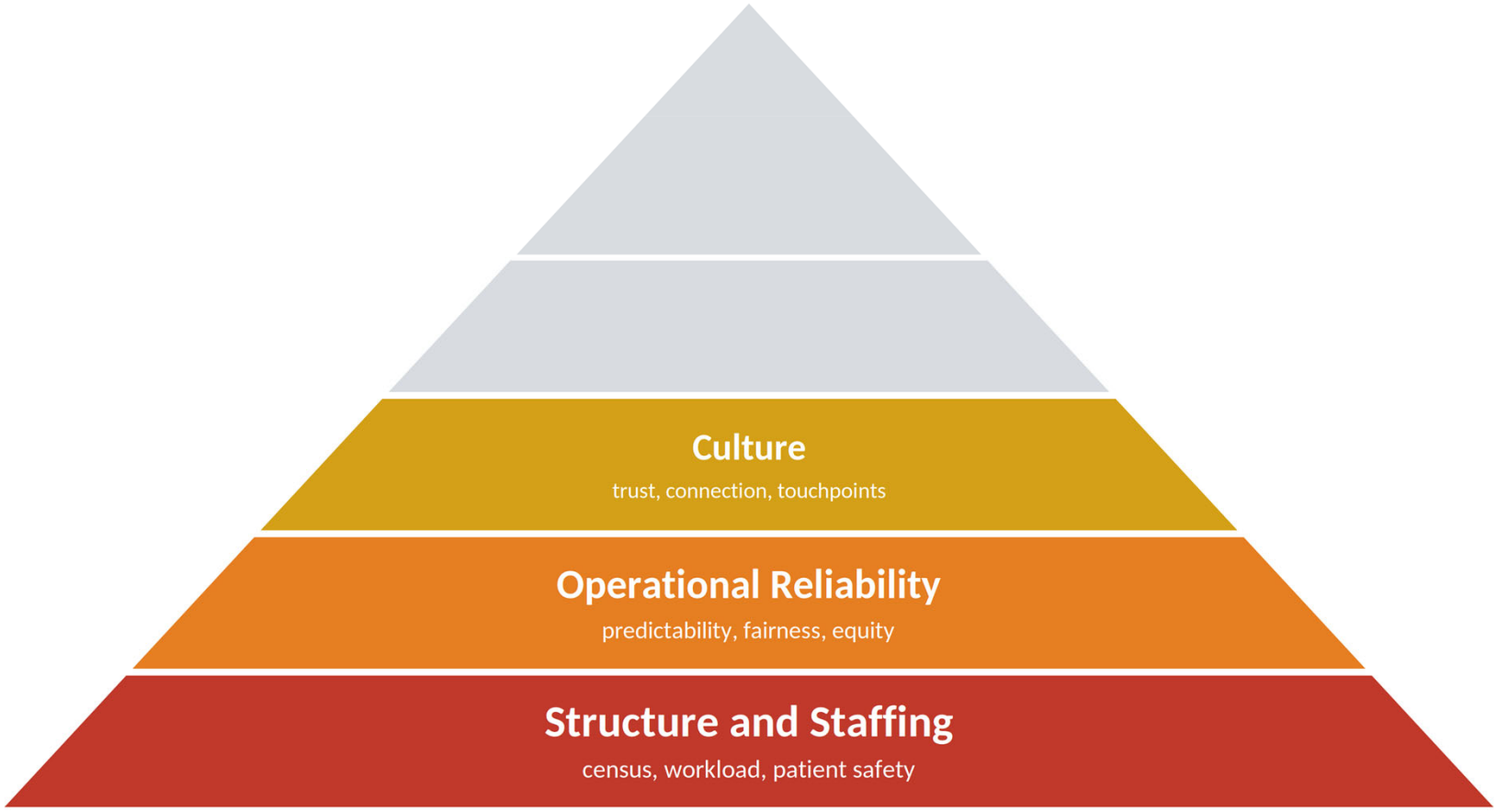
- Regular, expected department meetings - a predictable cadence, not called only when something's wrong
- High-level communication from leadership – (often email updates) census trends, staffing changes, strategic direction; no one learns big news through the hallway
- Clinical updates - protocol changes, new order sets, practice standards delivered consistently, not discovered mid-shift
- A real forum for discussion - standing time for frontline concerns and input, not just announcements read aloud

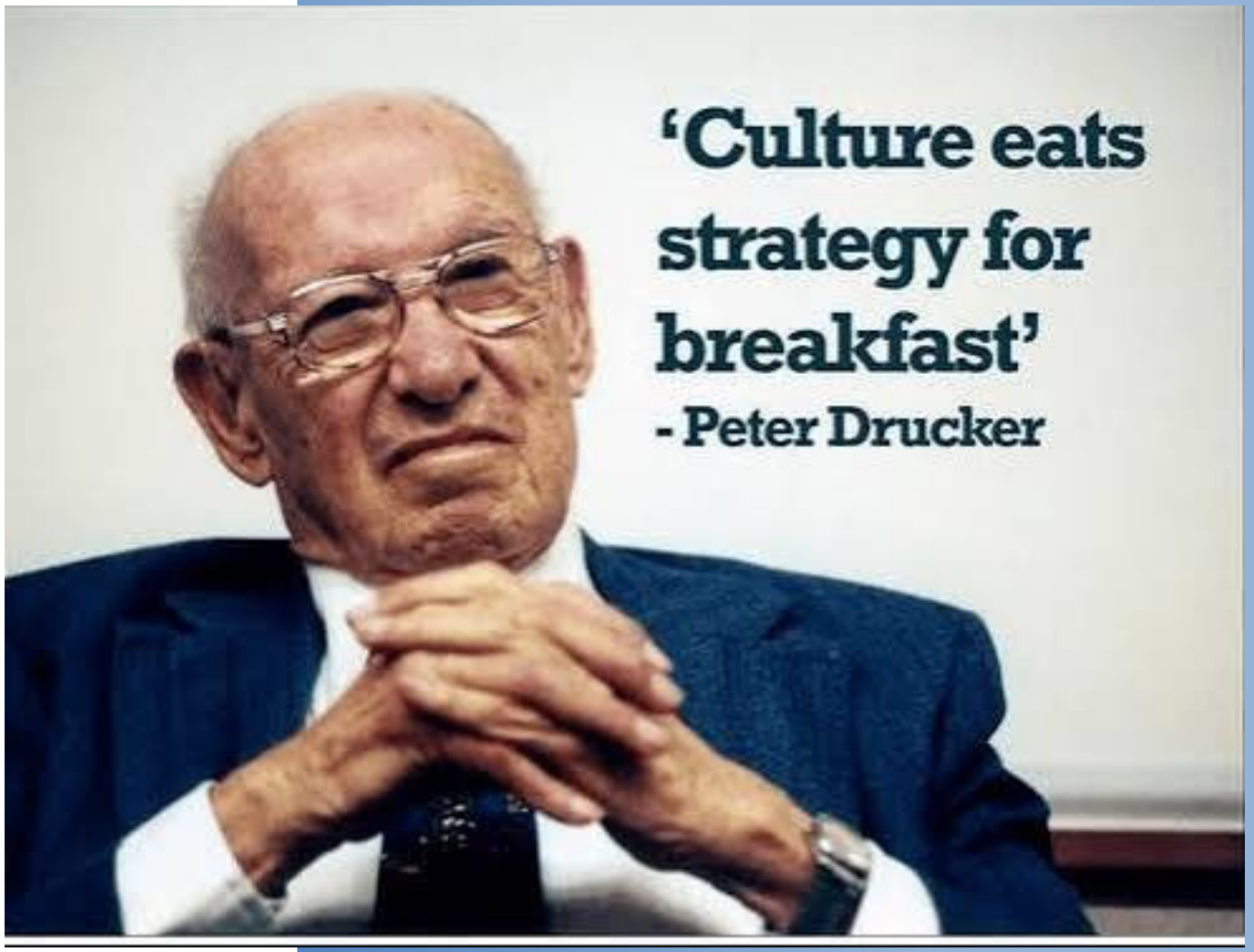
Responsive and Consistent Leadership

- When hospitalists strongly agreed that *"my supervisor, manager, or clinical leader seriously considers staff suggestions for improving provider well-being,"* fulfillment rose from 6.9% to 40.3%, and burnout fell from 74.1% to 25.5%

- The same pattern held for leaders *taking action* on well-being concerns brought to them (fulfillment 5.2%→41.5%, burnout 74.1%→23.2%) — and for *hospital executives* acting on well-being (fulfillment 11.2%→55.3%, burnout 69.6%→16.7%)

III. Belonging → Building Culture




'Culture eats strategy for breakfast'
- Peter Drucker

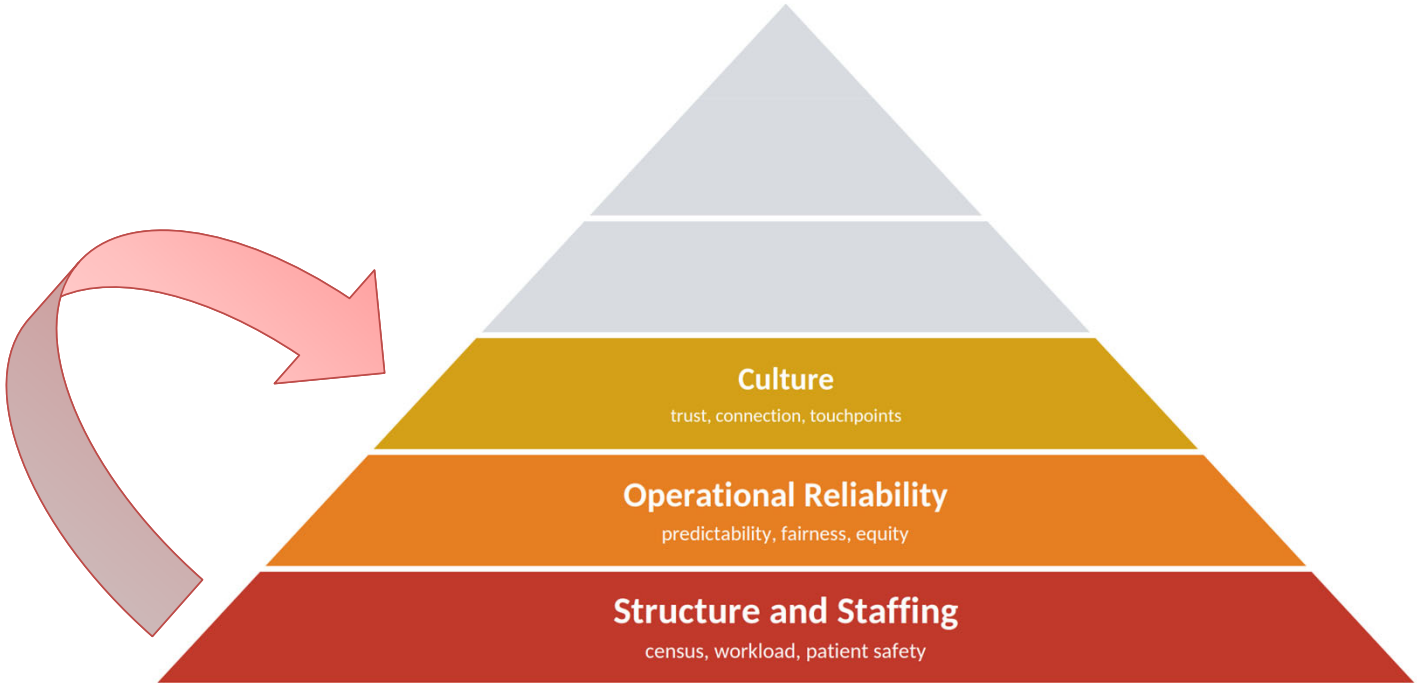
Culture

- A 100% staffed team, a fair and equitable schedule, well reasoned policies/procedures, and high level leadership with consistent communication guarantees nothing about how colleagues actually treat each other.

- This layer is what no policy can fully manufacture, but it can still be deliberately built and fostered.

Culture = Trust

Clinician selection feeds culture directly



Clinician Selection

- Culture is shaped by who gets hired in the first place - frontline input, hiring for fit and competencies - "would I trust this person to cover my patients at 2am”
- Selecting for understanding and grace - paired just as importantly with accountability and a genuine focus on patient safety
- Grace and accountability aren't a trade-off. Selecting only for "nice" without accountability creates a team that avoids hard conversations; selecting only for "rigorous" without grace creates a team that's brittle and blame-prone. Healthy teams benefit from both.

Increased Commu cation

=

Increased Trust

Gittell et al (2000)

- Studying hospital surgical care across nine hospitals, Gittell found that teams who's clinicians communicated frequently, accurately, and with mutual respect had shorter lengths of stay, better pain control, better functional outcomes, and higher patient satisfaction (after adjusting for patient factors)

Mechanisms for Increasing Touchpoints

- Naming the core structural problem: shift-based schedules are designed to minimize overlap between colleagues. Touchpoints have to be engineered back in deliberately.
  - Shared workspaces - a real, physical workroom where hospitalists overlap, rather than scattered/remote charting
  - Workgroups/committees - scheduling, protocol development, hiring panels - all shared task-based contact
  - QI projects - low-stakes collaboration, a title-free way to lead; bridges directly into Esteem
  - Team-building exercises - mixed reputation, but voluntary, low-pressure, and consistent (shared meals, informal social time)

Grace

- Grace internally: treating a colleague's mistake as information to learn from, not permanent evidence against them (giving the benefit of the doubt)
- Grace outward: extending the same good faith to nursing, consultants, the ED - hospitalists sit at the center of cross-department friction and set the tone
- Interdepartmental contempt ("the ED always does this...") is the same belonging-level failure as internal gossip, just aimed outward

Just Culture (James Reason, David Marx)

- Just culture: console human error, coach at-risk behavior, discipline recklessness.

- This is the operational form of grace-with-accountability, and it's the standard patient-safety citation for why blame-first cultures suppress error reporting

Grace + Accountability

- Grace is only real if the review process backs it up - same standard for everyone, systems-focused before individual blame
- If review is inconsistent (harsh for some, brushed aside for others), grace becomes something people compete for rather than something they can trust in
- Consistency isn't just schedules and backup, it's how the team responds when something goes wrong, from a one-on-one handoff to formal peer review

Psychological Safety

A shared team belief that interpersonal risk-taking is safe — you can ask, admit, disagree, and report without fear of humiliation or punishment. (Edmondson, 1999)

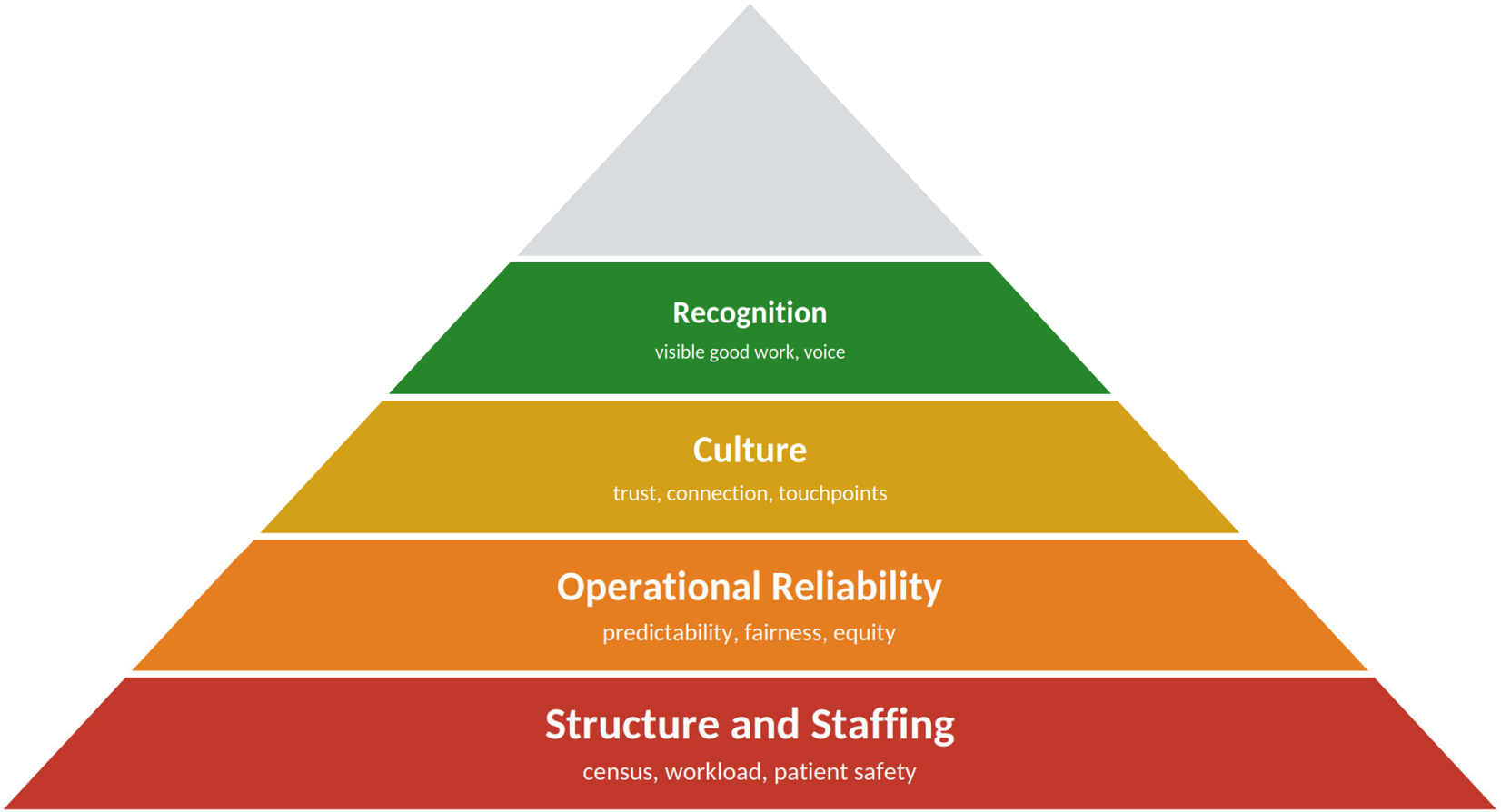
Not comfort or lowered standards — it's what makes high standards achievable, because problems surface early enough to fix.

BUCS: Behavior Undermining a Culture of Safety

- Conduct — overt or passive — that interferes with teamwork, communication, or safe patient care.
  - *Overt:* outbursts, intimidation, humiliation.
  - *Passive:* unanswered pages, condescension, refusal to collaborate.

- Joint Commission-defined; hospitals must have a code of conduct and a consistent process for addressing it. (Sentinel Event Alert #40)

IV. Esteem → Recognition



The Five Worst Words in Medicine?

THE FIVE WORST WORDS IN MEDICINE

Remember that patient you saw…

Remember that patient you saw…

- Every hospitalist's stomach drops; the pattern has trained them that this sentence is never followed by good news.
- An artifact of a more punitive era of medical training: feedback has come to mean correction and negative feedback
- Why it matters here: if the only time a hospitalist hears about a patient after the fact is when something went wrong, the environment has taught everyone that being noticed = being in trouble.

Feeling Valued: The Strongest Burnout Mitigator

- 37,685 healthcare workers, 208 US organizations (AMA Coping with COVID survey) - Only 45% felt valued

- Highly valued vs. not valued at all: **8.3x lower odds of burnout, 10.2x lower odds of intent to leave**

- What drives it: safety, fair compensation, transparent communication, teamwork, respectful leadership, organizational support
  (Stillman et al., *BMJ Leader*, 2024)


BEST
HOSPITALIST
of the
3RD WEEK
OF OCTOBER

The Evidence

- Recognition is a well-documented leadership behavior tied to lower burnout and higher professional satisfaction; physicians who rate their supervisors' leadership positively (including how well contributions are acknowledged) report meaningfully better well-being outcomes

- SHM 2026 Workforce Report found the same pattern - hospitalists who felt leadership valued their contributions had higher fulfillment, lower burnout

- Recognition is a well-supported, low-cost lever, and it's available to every clinician on a team, not just formal leaders

Cleveland Clinic Recognition Programs

1. **Recognizes excellence** - celebrates significant contributions to field, organization, and community
2. **Upholds the organization's reputation** - awards reflect institutional talent and values
3. **Strengthens physician engagement** - "acknowledging the impact physicians have made among their peers builds engagement"
4. **Inspires future generations** - recipients serve as role models for students and early-career physicians
5. **Celebrates legacy** - preserves the history of contributions

- Organizations with formal recognition programs have 31% less voluntary turnover than those without

What Good Looks Like

- Good saves - catching a subtle decompensation, a near-miss medication error, a nearly-missed diagnosis
- Good collaboration - a smooth handoff, backing up a colleague during a surge, cross-department teamwork that worked
- Going above and beyond - staying late to properly sign out a complicated patient, picking up a colleague's admission unasked

TeamHealth
2mo •

Congratulations to Dr. Hugh Loeffler, recipient of an Amazing Save Award at our 2026 National Medical Leadership Conference (NMLC)! This recognition honors clinicians whose expertise, composure, and decisive action make a life-saving difference when every second counts. During a critical airway emergency, Dr. Loeffler's exceptional clinical judgment and rapid response helped prevent respiratory arrest and ensure the best possible outcome for his patient. Please join us in congratulating Dr. Loeffler on this well-deserved recognition.

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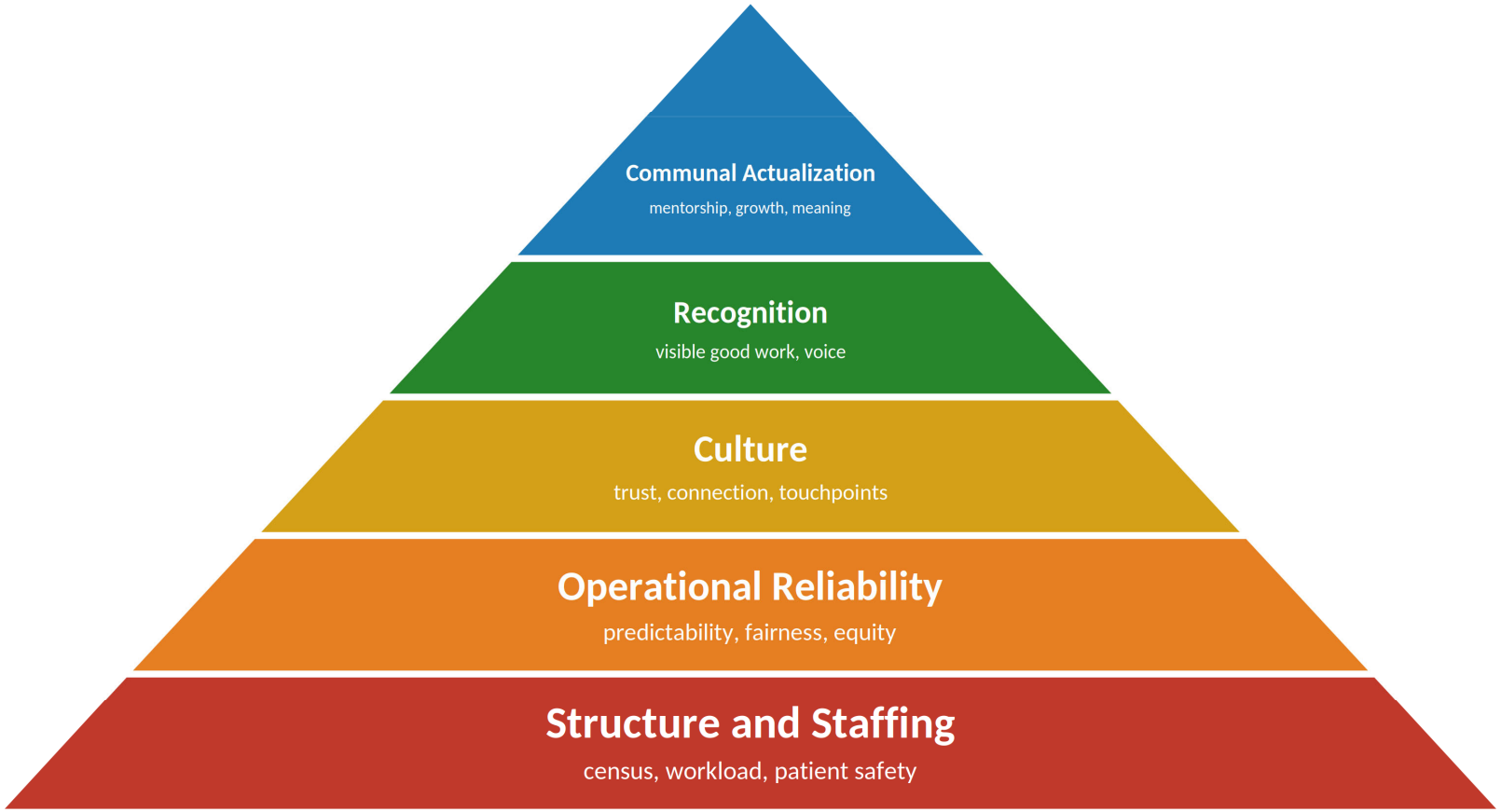
Spreading the Love

- Recognizing exemplary work from all colleagues (key focus on non-providers)

- Creating opportunities to shine:
  - Rotating project/workgroup leadership - scheduling committee, protocol/order set development, sepsis champion, patient experience champion, hiring panels - deliberately handed to different people over time, not concentrated with whoever's already senior or vocal
  - QI project ownership as one of the clearest title-free leadership opportunities in HM

- Quiet leadership-development pipeline: early-career hospitalists often discover leadership capacity with this kind of work

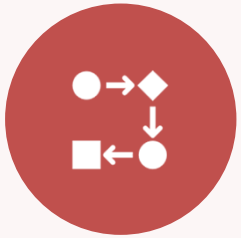
V. Self Actualization → Communal Actualization



Exemplary HM Groups

- High Quality
  - Low mortality, exemplary sepsis outcomes, low readmissions, high pt exp
- High Performance
  - Low GMLOS, good throughput, exceed metric expectations
- Fulfilled Clinicians
- Leadership Pipeline
- High Autonomy / ownership + proactivity
- Society involvement
- National Recognition
- Active Mentorship
- Low Burnout; High Retention / stability

Applying the Framework: Diagnose, Stabilize, Build



Diagnose honestly - Walk the five layers. Your level isn't your best initiative; it's the *lowest layer with a crack in it*

Locate your true level - Where does your program function *consistently?*

Stabilize before you climb - Name the single most important investment at that level, and the cheapest one. Start there

Then build the next layer - The sequence is the strategy: structure → reliability → culture → recognition → actualization

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Questions