The Role of the Hospitalist in the Healthcare Arena

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My Background
► Practicing Hospitalist since 1996
► Hospitalist Program Medical Director
  ▪ 50+ hospitalist group at 4 sites in San Francisco
► Physician Champion - Quality Initiatives
► Clinical Asst. Professor of Medicine
  ▪ CPMC Residency program
  ▪ Dartmouth Medical School
► Hospitalist Advisor to NORCAL Mutual since 2008
► NORCAL Director since 2012

Agenda for Today
► What is a Hospitalist?
► Identify risks associated with hospitalists
► Review hospitalist claims experience data
► Case studies and lessons learned
► Review risk mitigation strategies
  ▪ Focus on Handoffs
**Definition of A Hospitalist**

- SHM Definition: A physician who specializes in the practice of hospital medicine
- Core expertise: managing the clinical problems of acutely ill, hospitalized patients
- Also work to enhance the performance of hospitals and healthcare systems
- Hospital medicine: A medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients.

**Hospitalist Trends**

- Training
  - Usual: Internal Medicine, Family Practice, Pediatrics
  - MD or DO
  - Some Fellowships available – mostly research focused
- Rapid Growth of Hospitalist Field
  - General hospitalist
  - Nocturnists
  - SNFists
  - Subspecialty hospitalists

**Risk Areas for Hospitalists**

- Scope of Practice Issues
  - Practicing beyond scope of practice
- Co-management of patients
- Overly complex care – “Too many cooks”
  - Different messages given to pts/families
  - Poor inter-provider communication
  - Poor coordination of care
- Failure to exercise independent medical judgment
Risk Areas for Hospitalists

► Communication issues
  ▪ Failure to communicate with or communicating poorly with patients, families, staff and referring providers

► Handoffs:
  ▪ From PCP → ED → Hospitalist
  ▪ From Hospitalist → Hospitalist
  ▪ From Hospitalist → PCP/Next provider of care

Risk Areas for Hospitalists

► Staffing model issues
  ▪ Shift work mentality
  ▪ < 24 hr staffing and staffing from home
  ▪ Lack of timely consultative services

► Burnout
  ▪ Schedules can be grueling
  ▪ May lead to medical errors

► Allied Health Professionals
  ▪ Greater reliance on PA’s despite high acuity and patient complexity

Risk Areas for Hospitalists

► Emphasis on High RVU’s and productivity
  ▪ Hard to measure and reimburse for time spent
  ▪ Too many encounters, too little time

► Emphasis on Lower Length of Stay (LOS)
  ▪ May lead to premature discharges
  ▪ May lead to delay in diagnosis
  ▪ Often perceived negatively by pt and family
  ▪ May have incentives built in for lower LOS
Risk Areas for Hospitalists

► Emphasis on Observation Services
  ▪ May lead to delay in diagnosis
  ▪ Poor patient satisfier – higher copay for pts
  ▪ Leads to disgruntled patients and families

► Medication Reconciliation

► Incomplete Integration of Medical Records
  ▪ Loss of info on admission
  ▪ Long TAT labs/results that are not fully followed up after discharge
  ▪ Disjointed care with multiple specialists

► EHR Documentation
  ▪ Cutting and pasting of progress notes may poorly reflect pt's condition
  ▪ Quantity over quality
  ▪ Documentation to maximize billing rather than maximize thought process

► HIPAA Violations
  ▪ Texting and email regarding pts
  ▪ Often on non-secure servers, non encrypted emails
NORCAL Experience

▶ Failure to diagnose
  ▪ Spinal cord injuries
    ▪ Deficiencies in detecting Neuro emergencies
  ▪ Pulmonary emboli
  ▪ Acute abdominal catastrophe
    ▪ Bowel ischemia, perforation
  ▪ Sepsis – early diagnosis and initiation of Early Goal Directed Therapy

▶ Failure to Consult
  ▪ Obtain the consult and define the urgency

NORCAL Experience

▶ Co-management/Scope of Practice
  ▪ Hospitalist is front line provider on many surgical patients
    ▪ Training may not be adequate – lack of familiarity with many surgical conditions
    ▪ Consultants may not be readily available
    ▪ Resistance to having surgeon come in

  ▪ Post op management issues
    ▪ Who is responsible?
    ▪ Hospitalist is always called first

NORCAL Experience

▶ Medication Management Issues
  ▪ Anticoagulation
  ▪ Opiates
  ▪ Medication Reconciliation
Case Study Discussion

- Risk Evaluation
  - Patient Encounters
    - What is the optimal patient load/number of encounters per day?
    - Generally 12-16 patients max
    - >20 patients per day is NOT ideal and can lead to suboptimal patient management
    - Are there incentives tied to LOS?
  - Staffing Model
    - Shift work? Locums Use? Staff turnover rate?
    - Attention to continuity scheduling?
    - AHP use? If so, how much oversight?

- Risk Evaluation
  - Co-management of Patients
    - Are there clear guidelines or policies?
    - What are the expectations for the hospitalist on surgical pts?
  - Handoffs
    - Ask about a System for Handoff Procedure
    - How are Handoffs done between hospitalists? From hospitalist to PCP?
    - Look for a written policy/procedure around handoffs
Risk Mitigation

► Encourage optimized communication
  ▪ Train physicians on handling difficult patients/families
  ▪ Train physicians on how to communicate if mistakes happen
► Promote rigorous Handoff procedure
  ▪ Provide written handoff policy
  ▪ Provide sign out template
► Implement Policies for Co-Management
  ▪ Define roles/responsibilities

Example of Co-Management Guidelines: Orthopedic Hip Fracture

► ER Physician Responsibility:
  ▪ Call and discuss case with the orthopedist prior to calling the hospitalist.
► Hospitalist Responsibility
  ▪ Place all admission orders except those outlined below.
  ▪ Place orders for DVT prophylaxis.
  ▪ Do discharge summary/transfer summary.

Example of Co-Management Guidelines: Orthopedic Hip Fracture

► Orthopedist Responsibility:
  ▪ See patient on the day of admission if admitted before 6 PM, and by noon the next day if admitted after 6 PM.
  ▪ If the orthopedist does not see the patient in a timely fashion as outlined above, hospitalist reserves the right to consult a different orthopedist.
  ▪ Daily visits with a written note in the chart.
  ▪ Post-operative pain management
  ▪ Post-operative weight-bearing status & PT/OT
  ▪ Provide hospitalist group with a list of each surgeon’s pager or cell phone
Handoffs 101
► What is a handoff?
  ▪ Anytime a patient goes from one provider of care to another or one location to another
► What are the goals of a Handoff?
  ▪ Transfer sufficient information to the next provider of care
  ▪ Identify who is taking over the care of the pt
► JCAHO:
  ▪ Most sentinel events due to breakdown in communication occur during a handoff

Strategies to Improve Handoffs
► Face to face communication
  ▪ Use interactive process
  ▪ Allows for dialogue/questions/clarifications
► Verbal and written sign out
► Standardize format for handoff
  ▪ Checklist
► Allow adequate time
► Minimize interruptions

Strategies to Improve Handoffs
► Focus on ill patients
► Give insight to next provider – what to do, what to expect
  ▪ Have a to-do list
  ▪ Emphasize anticipated events
► Define transfer point
  ▪ End of shift, transition to another facility, etc
► Train new users on proper handoff
Elements of a Handoff Template

► Patient’s name and demographics
► Chronic diagnoses
► Code Status
► Pertinent medications
► Consultants
► Recent inpatient procedures
► Active clinical problems
► Anticipated events
► Cross-cover tasks – “To Do” list
► Overnight events

Transition of Care Issues

► Discharge is the ultimate handoff
► Discharge is a dangerous time
  ▪ Multiple opportunities for lost information
► Common Pitfalls
  ▪ Poor Communication with PCP
  ▪ Suboptimal Medication Reconciliation
  ▪ Inadequate follow up after discharge

Improving Transitions of Care

► Communication with PCP
  ▪ Should occur via phone call
    ▪ At time of admission
    ▪ With any significant changes in pt status
    ▪ At time of discharge
  ▪ Faxed or electronic discharge summary
    ▪ Needs to be done at time of discharge
  ▪ Faxed or electronic medication list
  ▪ Attention to any pending labs or studies
Improving Transitions of Care

► Medication Reconciliation
  ▪ List needs to be clear and legible
    • Pill Card
  ▪ Patient and family education about meds/indications/side effects
  ▪ Meds should be filled at the time of discharge ("doggie bag")
► Schedule outpatient follow up appt prior to discharge

Q&A