

The Internist in Both Worlds: The Intersection of Hospital and Outpatient Medicine

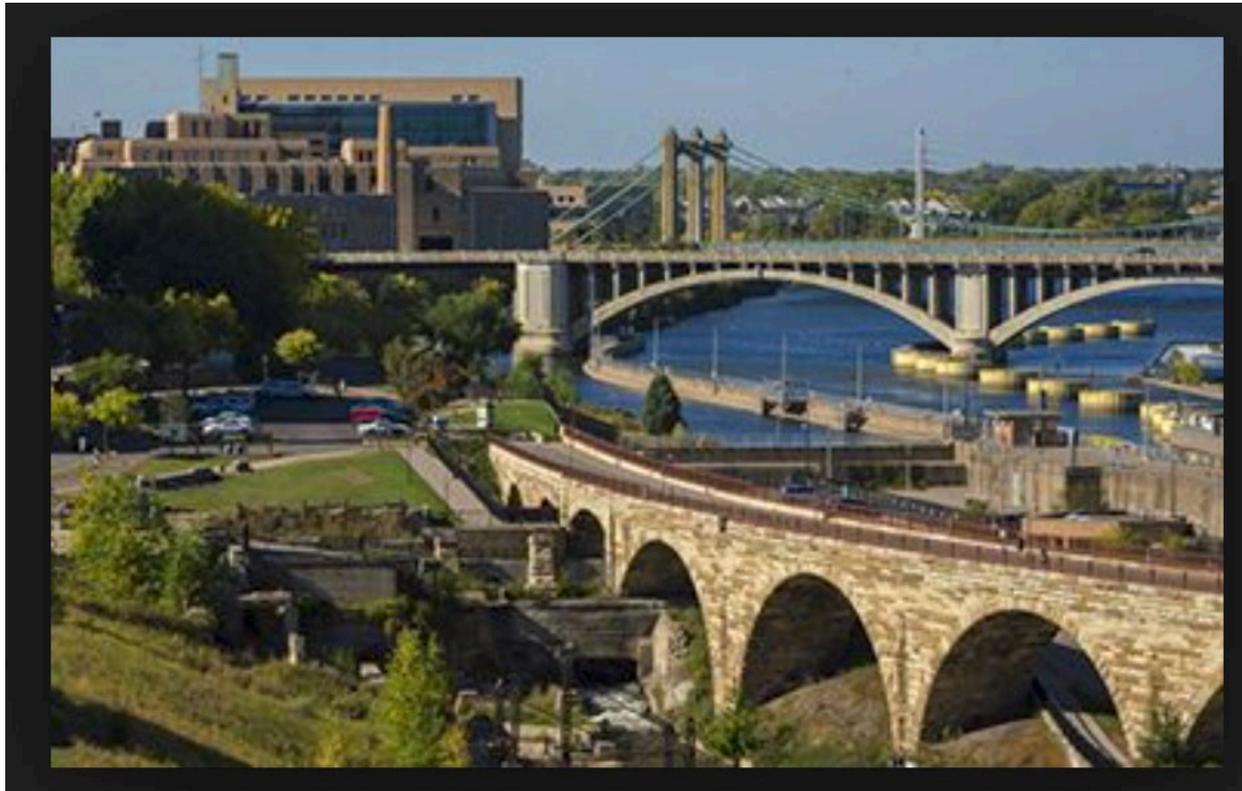
Heather E. Gantzer, MD, FACP
Internist, Primary Care, Park Nicollet Clinic
Nocturnist, Methodist Hospital, St. Louis Park MN
Chair-Elect, Board of Regents,
American College of Physicians

hgantzer@mac.com

Disclosures

- No financial disclosures
- No conflicts of interest
- Member of American College of Physicians
- Member of Society of Hospital Medicine

Flour Mill and Stone Arch Bridge



Silos are for grain



Where do you practice?

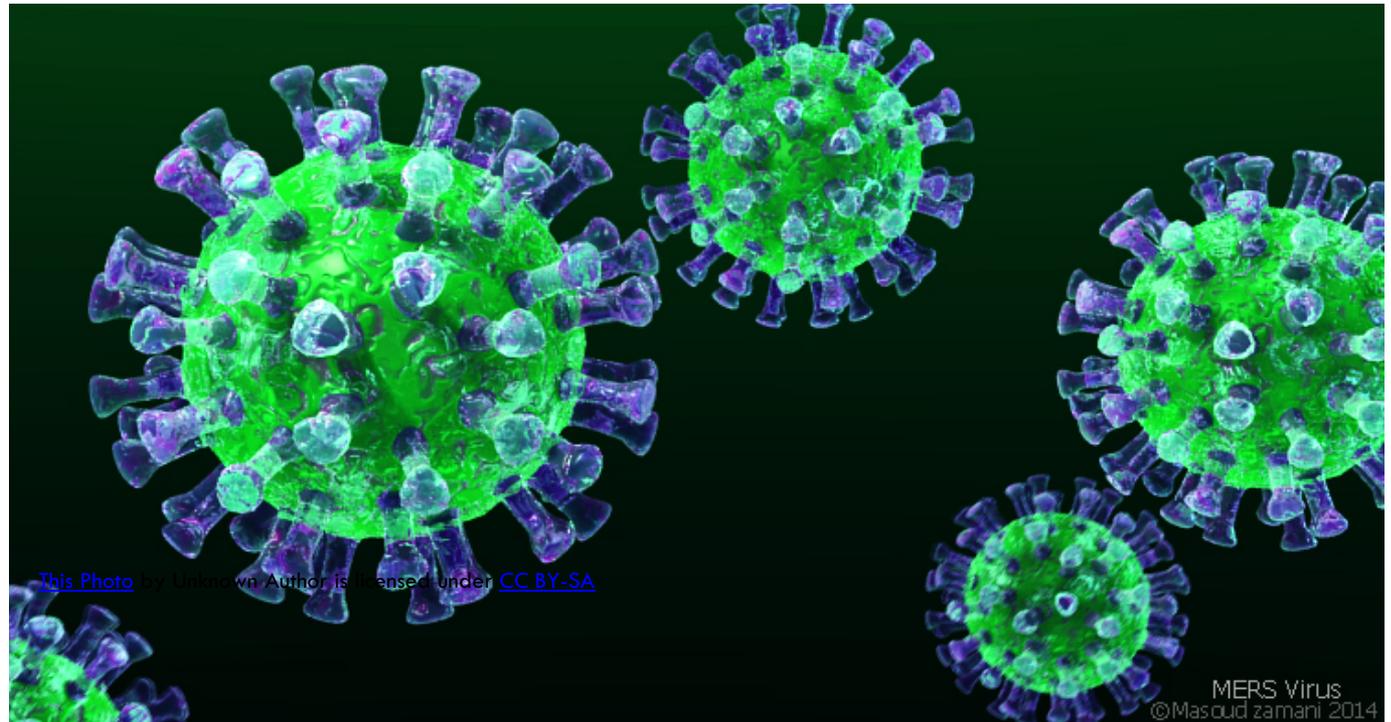
- A. Hospital
- B. Outpatient
- C. Both

Patient's journey is fluid

- Home
- Clinic
- Infusion center
- Observation status
- Inpatient status

- Post discharge clinic
- Skilled nursing facility/transitional care unit
- Hospital at home
- Telemedicine

Disease is often not contained solely within settings defined by humans : Coronavirus





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Outline

- History of Hospital Medicine
- Improvement opportunities in current systems at the intersection of inpatient and outpatient care
- Looking to the future-the role of the Internist in the patient's journey
- Also-advice from Hippocrates

Park Nicollet Hospitalists-our origin story

- Early 1990s Saturday morning clinic retreat
 - Dr. Paul Pattee identified lack of predictability in schedule of general internist as a major stressor
 - Proposed taking turns rounding in Methodist hospital
 - January 1994-first physician team on Methodist Hospital service in house 24 hours: 4 daytime rounders (one core hospital MD), one evening admitter, one night admitter

- 1994 Dr. Richard Freese : “The 24-Hour Service is more predictable for physicians, causing them to make fewer cancellations and have fewer behind-schedule days which makes for happier clinic patients”
- 1999 paper Ann Int Med confirmed improved care, reduced costs including shorter length of stay (.064d) and fewer specialty consultations, increased physician satisfaction, increased clinic patient satisfaction

- Patient and family satisfaction was maintained
- Clinic nurse satisfaction was down (initially rotating clinic physicians were out of clinic and in hospital two weeks at a time)

Current Park Nicollet Hospitalist Program

- 412 beds including 22 ICU beds, community hospital, part of multispecialty clinic system
- 51 core hospitalists, 4 NPs, 36 clinic rotating MDs
- 20 daytime rounding services of 13-15 patients with 1-2 admits and 3-5 discharges daily each
- 5 evening shifts, 1 moonlighting crosscover 6pm-10pm, 2 night shifts and a backup

Some advantages of a hybrid system

- Recruitment advantage for core hospitalists-
schedule flexibility for choice of shift, less
weekend and holiday work per hospitalist
- Recruitment advantage for clinic physicians that
want to continue in the hospital experience, and
those that want to concentrate completely on
clinic

- Moonlighting opportunities
- Staffing flexibility for surges and lulls in hospital patient volumes
- Increased interaction between hospital and clinic physicians

Disadvantages of Hybrid System

- “Herding cats”-can be difficult to meet regularly
- Maintaining knowledge base of hospital medical content, protocols
- Issues of procedural expertise-ultrasound, lines
- Ongoing responsibility of clinic MDs for their patients-the inbasket does not go away

Hospitalists: Drs. Wachter and Goldman

- Bob Wachter MD inspired by a 7am Sunday morning ACP presentation in the early 1990s
- August 15, 1996 NEJM Wachter Goldman article “The Emerging Role of “Hospitalists” in the American Health Care System”-also noted programs in Minnesota and Arizona
- Motivation was physicians wishing inpatient focus

- Lee Goldman cautioned “by definition, hospitalists build in discontinuity”-passing the baton; this remains the Achilles heel of hospital medicine
- Wachter “Hospitalists should have a systole (direct patient care) and a diastole (active relaxation phase) on quality improvement, teaching, research”

Society of Hospital Medicine

- Founded January 1997 by John Nelson and Winthrop Whitcomb
- Goals: promote quality of care of hospitalized patients, advance state of art of hospital medicine through education and research, improvement through innovation, collaboration and patient centered care, and support a membership of hospitalists

- April 1, 2017 CMA implemented a billing code C6 to designate hospitalists as a specialty to better benchmark their specialty utilization (instead of combining them with office-based generalists)

Improvement Opportunities in Current Systems: Communication

- Howard Beckman MD “Three Degrees of Separation” Ann Int Med 2009-sobering commentary on negative aspects of hospital care when not given by primary MD
- Communication issue: hospitalist and primary care

- Communication issues between hospitalist and consultants:
 - Consult requests: direct verbal, voice mail, or electronic order
 - Discussion of case
 - Implementation of recommendations

Primary Care Provider Preferences for Communication with Inpatient Team

- “One Size Does Not Fit All” March 2018 Journal of Hospital Medicine
- Surveys to three outpatient primary care practices near Johns Hopkins
- 42% received notification of hospital admits
- 88% wished communication at least once during admit

How did most outpatient physicians wish to be contacted by the hospitalist?

- A. Electronic health record
- B. Fax
- C. Telephone
- D. Homing Pigeon

- 54% of academic group preferred phone
- 8% of community groups preferred phone

- 77% of affiliated community group preferred EHR
- 23% of academics preferred EHR

- 58% nonaffiliated community group preferred fax,
- 0% of other groups preferred fax

- Conclusion: Identifying and incorporating primary care communication preferences may improve communication, though at potential expense of standardization and efficiency

Bridging the Hospitalist-Primary Care Divide through Collaborative Care

- Allan Goroll NEJM Jan 2015
- Proposed PCP visit hospitalized patient within 12-18 hours as a primary care consultant:
 - Direction and scope of patient's workup
 - Highlight pertinent family and psychosocial issues
 - Personalized inpatient evaluation and management
 - Challenges: time, workflow, payment model

Transitions of Care and Reducing Readmissions

- October 2012, Patient Protection and Affordable Care Act established the Hospital Readmissions Reduction Program, authorizing CMS to impose financial penalties on hospitals for excessive readmissions within 30 days of discharge
- Readmits affect 18.2% of Medicare beneficiaries and cost Medicare more than \$15 billion

A cry for help

- 2014-2017 firefighters visited 1,000+ patients recently discharged from Methodist Hospital, St. Louis Park, Minnesota, to discuss new medications, check blood pressure, and do a safety check around the house

HOMERuN: Hospital Network Reengineering Program

- Network of hospitals, hospitalists and care teams to use data to guide collaborative efforts to improve care of hospitalized patients
- Funding from Association of American Medical Colleges
- Graham, Kelly et, al, Preventability of Early Versus Late Hospital Readmissions in a National Cohort of General Medicine Patients. *Ann Intern Med.* 2018;168:766-744

Which readmissions were found to be more likely to be preventable?

- A. Early readmissions
- B. Late readmissions

- Review of 822 patients readmitted to 10 US academic medical centers
- 301 early (within 7 days) readmissions
- 36.2% preventable

- 521 late (8-30 days) readmissions
- 23.0% preventable

Early readmissions

- Early readmits nearly doubled the odds of preventability compared with late admissions
- Factors in early readmissions
 - Physician decision making (missed dx, inadequate rx)
 - Incomplete diagnostic workups (tests not done or results pending)
 - Premature discharge

Singh, H. Zwaan L. Reducing Diagnostic Error-A New Horizon of Opportunity for Hospital Medicine

- Ann. Int. Med. 18 October 2016:165 (8) H02-H04
- Diagnostic error: “missed opportunities to make a correct or timely diagnosis based on the available evidence, regardless of patient harm”
- Note-the number of tests performed does not necessarily correlate with the accuracy of the diagnosis

- Noted-hospitalists face external pressure to decrease length of stay and shift nonurgent evaluation and treatment to the outpatient setting

Late readmissions

- Inadequate monitoring and management of symptoms after discharge (long wait times)
- Factors outside the hospital
- Issues of end of life care (disease progression in terminally ill patient who desires aggressive care)

Understanding How to Improve Collaboration Between Hospitals and Primary Care in Postdischarge Care

- Nguyen DK et al. Journal of Hospital Medicine November 2014:Volume 9 NO. 11: p.700-706
- Hospitals have financial incentives to reduce readmission rate per the HRRP of CMS
- Unless part of an ACO that rewards (or penalizes) primary care for readmissions, resources spent by primary care to reduce readmits are not well reimbursed

Opportunities for Hospitalists to Improve Postacute Care Transitions-Ann.Int.Med 2018

- Care after discharge in SNFs and HHC (postacute care) can be a “black box”
- “Hospitalists often lack clarity about available resources, processes of care, and outcomes for patients discharged to PAC.”

Problem 1. Unrealistic expectations

- SNF physicians are allowed up to 30 days to complete and initial patient evaluation
- SNFs are only required to have an RN 8 hours per day
- Consider hospitalist training in SNF and HHC settings
- Advise Hospitalist to take leadership in PAC decisions

Problem 2. PAC Clinicians not receiving all information to provide optimal care

- Need info re indications and expected duration for lines and catheters
- Goals of care, code status, POLST
- Contact precautions
- Current cognitive and functional status
- Hospitalist contact info
- Paper copies of controlled substances (opiods)

Problem 3. Little Feedback to Hospitalists about Outcomes of Patients to PAC

- Often hospitalists are unaware of readmissions, and their causes
- Hospitalists and trainees could lead joint hospital-PAC reviews of readmitted patients, with the goal of identifying gaps in transitional care
- The ECHO-CT model could provide an opportunity for hospital and PAC clinicians to review readmissions together, identify opportunities for improvement

Looking to the future

- Examples of internists current working with subspecialized and general issues often crossing inpatient and outpatient settings: oncology, dialysis care, HIV care, medical directors of SNF/TCUs
- Roles of support systems including EHR, order sets, teams, and families

- Roles of mutual respect and interaction
- Roles of reducing diagnostic error, and of lifelong learning

The site(s) of medical care in the future will continue to evolve

- The medical expertise of the internist, and ability to work in effective teams to deliver care in settings that make the most sense in terms of effectiveness, safety, patient preference, and cost effectiveness, may be implemented in a variety of inpatient and outpatient areas

Internal Medicine in Hospital and Outpatient Setting

- Value of Internal Medicine training and perspective is foundational and strong in multiple settings
- Communication with colleagues in different areas, and lifelong learning, are imperative

Gustave Stickley Craftsman magazine 1901



Geoffrey Chaucer, The Parliament of Fowles, 1382

- “The lyfe so short, the craft so longe to lerne”

Hippocrates, c. 460-357 BCE

- “Life is short, and Art long: the crisis fleeting; experience perilous, and decision difficult.
- The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate.”

1962 ACP Mace, of Plane Tree, Isle of Cos, where Hippocrates taught



Summary

- Hospital medicine grew as a specialty in 1990s
- Internists may serve inpatient, outpatient or both
- As with other specialties, areas of focused expertise balance with breadth of knowledge and experience
- Our patients do not remain in silos but travel among areas depending on their need, and Internal Medicine supports them on their journey
- Communication between physicians, mutual respect, and lifelong learning support their care

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