Fostering Excellence in Internal Medicine:  
*The State of Hospital Medicine*

**Alabama / Mississippi**  
ACP Chapter Meeting  
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Andrew Dunn, MD, MPH  
Professor of Medicine  
Chief, Division of Hospital Medicine  
Mount Sinai Health System  
New York, NY

**DISCLOSURES**

- Desai Pharmaceuticals – research funding
- Pfizer / BMS – research funding

**GOALS**

- Describe the evidence and evangelism behind HM
- Current and growing scope of hospitalists
- Uncharted territory – The future of HM and US Healthcare

**Zero to 60 (Thousand)**

**RESIDENT WORK HOUR LIMIT**

- 1997—The Society of Hospital Medicine founded
- 2006 –The Journal of Hospital Medicine

**State of Hospital Medicine**

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www.hospitalmedicine.org
State of Hospital Medicine

- 2006 – SHM develops “Core Competencies”
- 2009 - ABIM creates Focused Practice in Hospital Medicine (FPHM)
- 2017 - CMS adopts “C6” hospitalist specialty code
- Approximately 70 hospital medicine fellowships nationwide

You might be a hospitalist medical director if you immediately translate “All charges were dropped” into “Can start next week.”

State of Medicine

- Retrospective cohort study, community teaching hospital in San Francisco
- 5,710 patients over 2 years
  - 3,693 (65%) were cared for by community-based physicians
  - 1,615 (28%) were cared for by hospitalists
  - 402 (7%) were cared for by rotating faculty
- Hospitalists patients were younger, more likely to be black, more likely to have Medicaid or no insurance, and more likely to be admitted from the emergency department

- Decreased LOS
- Decreased costs
- Decreased deaths in house and at 30 and 60 days
- Similar readmission rate, use of consultants


- Cohort study of 6511 patients admitted to the general medicine service at the University of Chicago over a two year period
- 4898 (75%) assigned non-hospitalists and 1613 (25%) to hospitalists


- Decreased LOS
- Decreased average costs
- Mortality - No difference year 1
- Mortality - Significant decrease year 2


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**Database of Abstracts of Reviews of Effects (DARE)**

- Retrospective and prospective studies, adults
- Compared LOS between hospitalist and non-hospitalist groups
- Definitions of ‘hospitalist’ ranged from membership in SHM to spending 25% - 100% of time caring for inpatients
- Comparator groups included primary care physicians, family medicine, non-hospitalists, and private physicians
- Most participants were general hospitalized in-patients; some focused on specific diagnoses

Database of Abstracts of Reviews of Effects (DARE)


502 abstracts identified
17 studies of 137,561 patients
Significant heterogeneity between studies

LOS shorter in the hospitalist group compared with the non-hospitalist group, -0.44 days (p<.001)
Non-resident service: LOS shorter in the hospitalist group (0.68 days, p<.001)
Cost: Similar (11 studies)


Hospitalists: lower LOS (0.64 days) and hospital charges ($282)

- Medicare costs in the 30 days after discharge $332 higher
- Hospitalist patients less likely to be discharged home
- Hospitalist patients more likely to have ED visits and readmissions
- Hospitalist patients had fewer visits with their PCP


Hospitalists and PCPs

- Hospitalist patients had lower LOS but less likely to be discharged home and higher 30-day mortality

Hospitalists and non-PCPs

- Hospitalists were more likely to discharge patients home and decreased LOS, readmissions, and mortality


Communication Deficits

- Systematic review
- 55 observational studies investigating communication and information transfer at hospital discharge
- 18 controlled studies evaluating the efficacy of interventions to improve information transfer

Communication Deficits

- Direct communication between hospital physicians and primary care physicians: 3%-20%
- Availability of a discharge summary at the first post-discharge visit: 12%-34%; affected quality of care in 25% of visits
- Discharge summaries lacked:
  - diagnostic test results (missing in 33%-63%)
  - hospital course (7%-22%)
  - discharge medications (2%-40%)
  - test results pending at discharge (65%)
  - follow-up plans (2%-43%)


Barriers to Communication

- Qualitative study of the perceptions of physicians
- Inpatient and ambulatory physicians noted similar challenges
  - time constraints
  - difficulty contacting other clinicians
- Issues specific to their specialty
  - Hospitalists reported difficulty making timely follow-up appointments
  - PCPs reported not being aware when their patients were hospitalized
- Themes for successful care coordination identified
  - increased efforts for patients at highest risk
  - shared electronic medical records (EMRs)
  - clear accountability
  - direct telephone access

Cross-sectional study at an academic hospital
Teaching effectiveness on general med wards
Compared hospitalists, general medicine outpatient, subspecialists
Clinical Tutor Evaluation (CTE) tool - valid and reliable method of rating teaching effectiveness
423 house staff and medical students eval 63 teachers

Hospitalists and general medicine attendings generally rated as more effective teachers than subspecialists
Hospitalists similar to general medicine attendings
Younger attendings favored over older attendings

Leading in Quality Improvement For Hospitalized Patients
- VTE Prevention
- Glycemic control
- Handoffs
- Transitions of care
- High-value care
- Teamwork
- Medication reconciliation
- Opioid management

Impact of Geography on Teamwork
Single center study with pre-post design. Interviewed MDs and RNs before and after localizing teams to units.
Geography – 209/285 (73%) of patients localized to corresponding team’s units.
Ability of MD and RN to identify each other
- RN: 93% vs 71%
- MD: 58% vs 36%

Structured Interdisciplinary Rounds (SIDR)
- Structure
- Scripting
- Time management
- Performance assessment - individual and team
- Compared SIDR with standard rounds on a control unit
- Teaching service, Geographic, 30 bed
- 11:00am daily, 30-40 minutes
Structured Interdisciplinary Rounds (SIDR) - Communication Tool


SIDR - Results

LOS - unchanged: 4.3 vs 4.1 days
Cost - unchanged: $89,070 vs $89,044

Structured Interdisciplinary Bedside Rounds
SIBR - Emory

Transformed IDR to a bedside model – Mobile Interdisciplinary Care Rounds (MICRO)
Compared MICRO with standard rounds on a control unit
Non-teaching service
10:00am daily, 40 minutes


Bedside Interdisciplinary Rounds

• LOS: unchanged
• Clinical deterioration: unchanged

FALLS
COMMUNICATION WITH PHYSICIANS

LABS W/IN 24 HOURS OF DISCHARGE
**Scope of Hospital Medicine**

- Co-management
- Observation Units
- Skilled Nursing Facilities
- Post-discharge Clinics
- Critical Care
- Palliative Care

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
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**Observation Units**

*The Evidence*

Hospitalists vs Emergency Medicine

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**Surgical Comanagement by Hospitalists Improves Patient Outcomes**

- Single institution
- Orthopedic and NS Services
- Over 20,000 patients
- Propensity matching
- Outcomes: Complications, LOS, Readmission rate, Pt sat


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**The effect of a hospitalist comanagement service on vascular surgery inpatients**

- Single center
- Vascular surgery
- ASA III-IV
  - Increased CMI
  - Decreased mortality
  - Decreased pain
  - No change in LOS or readmissions
  - Surgical hs reported improved patient care and educational experience


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**Hospitalists and the Decline of Comprehensive Care**


"The true core of good medicine is not an institution but a relationship — a relationship between two human beings. And the better those two human beings know one another, the greater the potential that their relationship will prove effective and fulfilling for both. Models of medicine that ensconce physicians more deeply in spatial and temporal silos only make the prospects for such relationships even dimmer."
Decline of Comprehensive Care

- “The increasing number of hospitalists cannot, in and of itself, be taken as conclusive evidence of benefit.”

- “…increasing the number of physicians involved in a patient’s care creates opportunities for miscommunication and discoordination, particularly at admission and discharge.”

- “…hospitalists may become progressively less accountable to non-hospitalized patients and their communities, ultimately becoming less effective advocates for comprehensive medical care.”

Current State

- The dominant model of care in the U.S.
- Specialists – expertise in inpatient management
- Contributing to the quality, educational, and research missions of their institutions
- Decrease LOS and inpatient costs
- Can lead to higher post-hospital costs and readmissions due to discontinuity
- Expanding roles and scope without an evidence-base
- Demands for better performance while swept along in tide of an increasingly fragmented system
- Disruption and opportunity are imminent

Trends in Healthcare

- Consolidation
- Value-based payment
- Advanced payment models
- Vertical integration
- External disruption
- New direction

Consolidation

Value-based Payment
86 QPP measures relevant to ambulatory practice
832/86 (97%) rated as valid
NQF-endorsed measures: 57% validated


Alternative Payment Models

- Foster innovation / coordination
- Advanced APMs
  - ACOs
  - CPC Plus
  - BCPI – bundled payment
- Population health
- Telehealth
- Hospital at Home
- Hospital – SNF alignment

Vertical Integration

PAYER

- HOSPITALS
- PHYSICIANS
- SNF/HOSPICE
- PHARMACY
- ANCILLARY SERVICES
- BEHAVIORAL HEALTH

Disruption!

CVS/Aetna merger - Potential to lower medical costs. Engage with members as they purchase drugs at pharmacies or through its prescription drug programs.

May foster increased use of lower-cost care at CVS stores and Minute Clinics.

Disruption!

New Directions

- Alignment, not distortion
- Coordination, not fragmentation
- Transparency, not impenetrable
- Quality, not quality measures
- Patient-centered, not payment centered
- Supports physician wellness, not burnout
The Hospitalist’s Role in Achieving Excellence in Healthcare

- Leading in quality, education, innovation, research
- Active role in shaping the future
- Expanded goals and roles to improve outcomes and costs – ACOs, bundled payment, vertically integrated systems
- Promoting high-quality, patient-centered care within and across venues of care and stages of wellness and illness

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THANK YOU!

Questions?