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

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Flour Mill and Stone Arch Bridge
Silos are for grain
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
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
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 admittter, one night admittter
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 length of stay (.64d) and 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 crossover 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 not 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
- 54% of academic group preferred phone,
  - 8% of community group preferred phone

- 77% of 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
Next generation of communication

- Patients’ increasing interest in reviewing their own records during their hospitalization
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
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)
- Premature discharge
- Incomplete diagnostic workups (tests not done or results pending)
Singh, H. Zwaan L. Reducing Diagnostic Error-A New Horizon of Opportunity for Hospital Medicine


- 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


- 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
SHM BOOST: Better Outcomings by Optimizing Care Transitions

- Assessing for risk for adverse events after discharge, the 8 Ps:
  - Problems with medications
  - Psychological
  - Principal diagnosis
  - Physical limitations
  - Poor health literacy
  - Prior Hospitalizations
  - Palliative care: surprised if patient died within a year?
Changed the calculation of the payment adjustment factor congruent with the 21st Century Cures Act to assess penalties based on a hospital’s performance relative to other hospitals treating a similar proportion of Medicare patients also eligible for full Medicaid benefits.
Patient Satisfaction

- **SHM**: “everything we say or do that affects our patients’ thoughts, feelings and wellbeing”
- **CMS**: “patient experience is not the same as customer satisfaction” i.e. not “happiness”

- **HCAHPS**: Hospital Consumer Assessment of Healthcare Providers and Systems survey
- **CG-CAHPS**: Clinician & Group Survey for MIPS
- **AHRQ, CMS**
Patient Experience as a Health Care Value Domain in Hospitals


- Hospitalist leaders should promote a better understanding of HCAPS data, including the survey’s limitations

- Hospitalists should develop innovative strategies for assessing the patient experience in real time
Current CMS guidelines prohibit hospitals from conducting their own patient experience models, for fear of skewing the HCAPs results.

Low tech approach: “How do you feel things are going for you here in the hospital? What would you like to improve?”
Connection between the patient’s care experience and the clinician’s work experience

An area where physician wellness is critical for patient and physician
Looking to the future

- Examples of internists current working with subspecialized and general issues inpatient and outpatient: oncology, dialysis care, HIV care, medical directors of SNF/TCUs

- Roles of support systems including EHR, order sets and teams
- Roles of mutual respect and interaction
- Roles of reducing diagnostic error, and of lifelong learning
Internal Medicine in Hospital and Outpatient Setting

- Value of Internal Medicine training and perspective is foundational and strong in multiple settings

- Communication with colleagues, 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”
“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
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 of need, and Internal Medicine supports them on their journey
- Communication between physicians, mutual respect, and lifelong learning support their care
References


