

**California Medical Association  
Organized Medical Staff Section (CMA-OMSS)  
2010 Annual Assembly**

Friday, October 1, 2010  
7:30 am – 5:00 pm

Sacramento Convention Center  
Room 204

7:30 AM – 8:00 AM	Registration and Breakfast	
8:00 AM – 8:15 AM	Welcome and Introductions	James Hinsdale President-Elect, CMA
		Dustin Corcoran CEO, CMA
8:15 AM -9:00 AM	Medical Staff Governance: Top Ten Ways Medical Staff Can Protect Patient Care	Gregory Abrams, Esq.
9:00 AM - 11:30 AM	OMSS and HOD Resolutions and Reports	Lytton Smith, MD Chair, CMA-OMSS
11:30 AM – 12:00 PM	Medical Staff Issues – Open Forum	Lytton Smith, MD Chair, CMA-OMSS
12:00 PM – 12:45 PM	Lunch & Legislative Update	Jodi Hicks, CMA Government Relations
12:45 PM – 2:00 PM	Accountable Care Organizations	Anthony Schiff, Esq.
2:00 PM – 3:15 PM	Hospitalists and Community Physicians: Partnering for Quality Patient Care	Andrew Auerbach, MD
3:15 PM – 3:30 PM	Afternoon Break	
3:30 PM – 3:45 PM	Candidate Speeches and Elections	
3:45 PM – 4:00 PM	AMA-OMSS Update	
4:00 PM – 4:15 PM	Legal Update	
4:15 PM	Adjourn	



**California Medical Association**

*Physicians dedicated to the health of Californians*

Strategies to Protect Quality Through Medical Staff Self-Governance

- Medical staff self-governance is vital to the delivery of quality patient care but has become increasingly more difficult to achieve
- CMA has developed a 10 step strategy for medical staffs to take to help them achieve self-governance



# The 10 Step Strategy: Goals

1. Achieve and maintain self governance
2. Establish a common set of expectations between the medical staff and hospital
3. Increase compliance with Joint Commission and legal standards
4. Reduce conflict and confusion among medical staffs and hospitals, allowing them to focus on protecting patients



# Step 1

Secure an independent attorney to represent the medical staff



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Independent legal counsel....

- Helps avoid conflicts of interest with the hospital
- Insures that legal interests of the medical staff are fully represented
- Is a right of the medical staff (given that it is at their own expense) and is guaranteed by statute (Business & Professions Code §2282.5(a)(5)).



# Step 2

Adequately structure dues and  
allow medical staff to control  
medical staff funds



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Control of medical staff funds...

- Allows medical staff to seek external assistance in achieving self-governance and to safeguard their patients;
- Assess dues to support their needs; and
- Use dues to increase medical staff participation



# Staff funds should...

- Be kept in a separate bank account to protect self governance rights and insure access
- Have oversight to ensure funds are being spent efficiently and effectively



# Step 3

Govern through bylaws, not documents unapproved by medical staff



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Medical staff bylaws are...

- A binding agreement between the hospital, the medical staff and its individual members
- Provide a framework for self-governance
- Are enforceable by the Joint Commission and by court order



# Bylaws should be...

- Reviewed by the bylaws committee and an attorney representing the medical staff to ensure they support the goals of self-governance



# Step 4

Have the bylaws committee serve as  
a self-governance ombudsman



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# The bylaws committee will...

- Conduct an annual review of medical staff bylaws, rules, and regulations
- Evaluate concerns relating to the ability of the medical staff to be self-governing
- Develop recommendations for changes in medical staff documents and operations
- Review hospital bylaws and policies for inconsistencies and conflicts with medical staff documents



# Step 5

Allow medical staff to select  
their own leaders



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# The exclusive right to select its own leaders...

- Maintains the spirit and letter of self-governance by preventing the hospital governing body from interfering with the selection of department directors and division chairs, who are responsible for evaluating the clinical work and quality of patient care performed in their respective areas.
- Will make medical staff accountable for their own representation



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# To prevent improper influence from the hospital...

- The hospital should fund “block grants” to the medical staff to “pay” leaders for their services they perform on the behalf of the medical staff; and
- Such funds should be under the sole control of the medical staff



# Step 6

Avoid conflicts of interest and make decisions in the best interest of medical staff and patient care



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Step 7

Be transparent and provide medical staff members with the information they need to participate meaningfully in medical staff affairs



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Increase meaningful participation in medical staff affairs through...

- Use of a sliding scale dues structure, dependent upon levels of participation
- Introducing mechanisms that make medical staff operations more transparent, accountable, and representative.



# Step 8

Let medical staff to  
take ownership of quality



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Take ownership of quality through...

- Credentialing of physicians and other health care practitioners who practice independently in the hospital
- Patient care review
- Periodic review of contracting decisions for quality implications
- Addressing code of conduct issues in medical staff bylaws



# Step 9

Be involved with the hospital.

The hospital's business is the  
medical staff's business



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# Increased involvement with the hospital ...

- Will help bridge the connection between “business” and “administrative” decisions with the practice of medicine
- Should include the ability of medical staff to elect its own members of the governing body
- Should include the involvement of medical staff in the strategic planning of the hospital in areas affecting quality of care and the functioning of the self-governing medical staff



# Step 10

Establish a fair dispute resolution mechanism



**California Medical Association**  
*Physicians dedicated to the health of Californians*

# To ensure fairness in resolving disputes...

- The chairship of the Joint Conference Committee should alternate between representatives of the board of trustees and medical staff every other meeting
- The chair representing the medical staff should not have financial ties to the hospital



# CONCLUSION

These steps can take a considerable amount of time to achieve. But the time it takes is worth it as self-governance exists to protect quality of care.





**California Medical Association**

*Physicians dedicated to the health of Californians*



# **ACCOUNTABLE CARE ORGANIZATIONS**

---

**Organized Medical Staff Section  
California Medical Association  
October 1, 2010**

**Anthony Hunter Schiff, J.D., M.P.H.  
Principal, Schiff and Bernstein, APC  
Professor (Adj.), Department of Health Services,  
School of Public Health, U.C.L.A.**



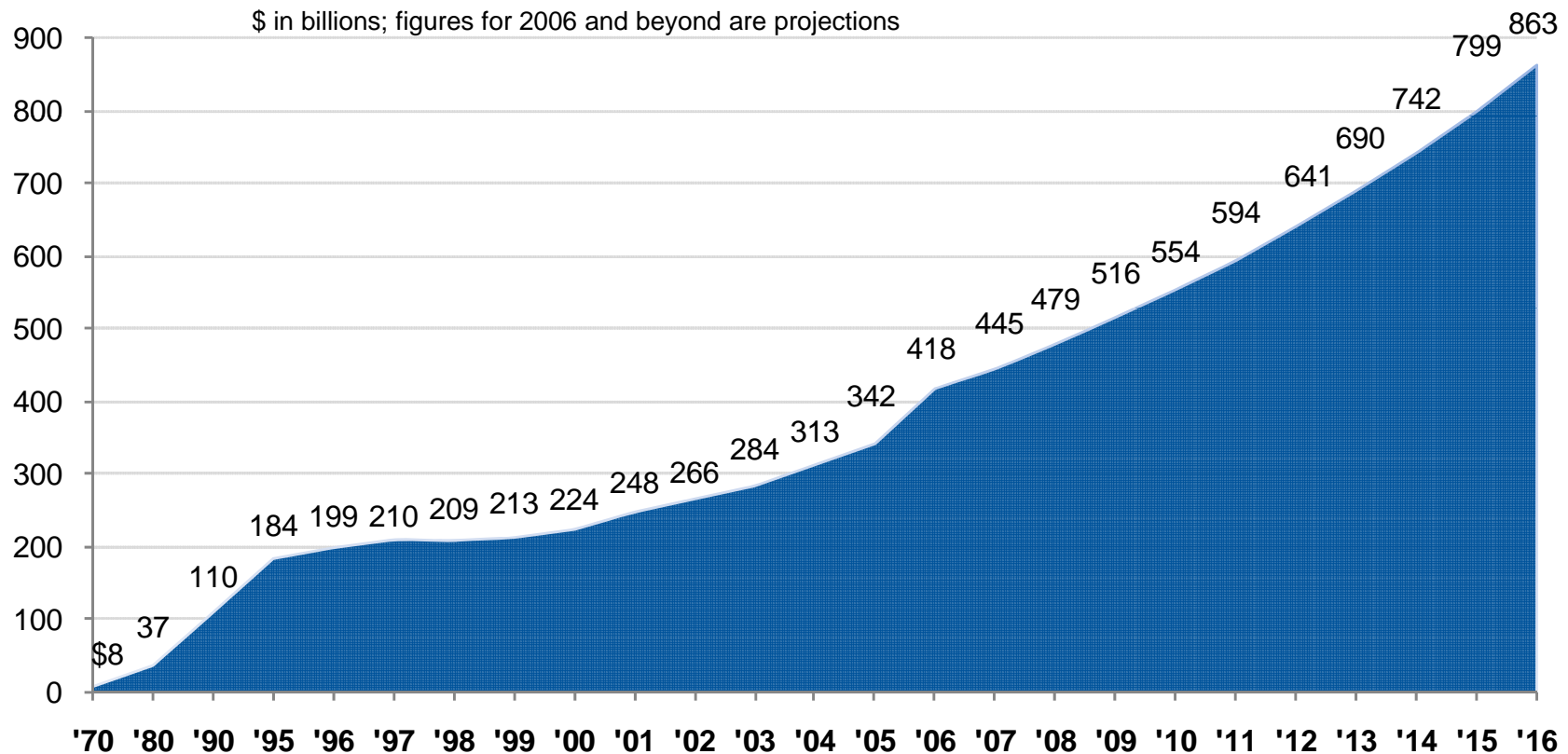
# INTRODUCTION

---

- Multiple delivery systems and markedly different geographic regions make a single legislated health care reform solution practically impossible
- Physicians, hospitals and insurance companies are all developing models
- Quality and value will be key benchmarks of health care reform

# MEDICARE SPENDING

Medicare Spending  
CY 1970 - 2016



Source: Modern Healthcare's By The Numbers - December 2007 (CMS, 877-267-2323, cms.gov)



## THE CALIFORNIA HEALTH CARE ENVIRONMENT

---

- Growing and aging population
- Increasing demand for medical services

### Declining number of hospitals and hospital beds

- SB 1953
- Significant number of hospitals are losing money on operations
- Underfunded pension obligations are another burden for many hospitals
- The “have” and “have not” hospitals



# THE INSURANCE INDUSTRY

---

Major consolidations between/among third party payers have yielded significant concentration of market power

- February 2010 Anthem/Blue Cross of California announced up to 39% increase
- The House voted on February 24, 2010 to repeal McCarran-Ferguson Act antitrust exemption for *health* insurance companies

Catholic providers reinvent themselves as industry changes / Page 10

# Modern Healthcare

THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY

AUGUST 16, 2010

\$5.50

## THE COMPENSATION ISSUE

OUR ANNUAL LOOK AT WHO'S MAKING WHAT

*UnitedHealth Group's Stephen Hemsley took home more than \$106 million in compensation and exercised stock options last year / Page 6*

NEWSPAPER



## MARKET DRIVEN REFORM

---

- The speed of health care delivery changes in a given geographic region will be significantly impacted by the amount of competition between/among hospitals **and** the numbers and types of physicians
- The work loads and responsibilities of providers will likely continue to increase (due in part to improved informatics), but revenue will likely continue to decline per unit of work



# ACCOUNTABLE CARE ORGANIZATIONS

---

- ACA describes 5 different ACO models
- Primary care physicians are key to holding lives
- In-network incentives
- Out-of-network disincentives
- Where do ACOs take the provider community?



# ACCOUNTABLE CARE ORGANIZATIONS

---

## Eligible ACOs (The Big 5)

“...the following groups of providers of services and suppliers which have *established a mechanism for shared governance* are eligible to participate as ACOs under the program under this section:

1. “...ACO professionals in group practice arrangements.
2. “...Networks of individual practices of ACO professionals.
3. “...Partnerships or joint venture arrangements between hospitals and ACO professionals.”
4. “...Hospitals employing ACO professionals.”
5. “...Such other groups of providers of services and suppliers as the Secretary determines appropriate.”



# ACCOUNTABLE CARE ORGANIZATIONS

---

Shared Savings Program –

Statutory Definition

“...Not later than January 1, 2012, the Secretary shall establish a shared savings program... that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery...”



# ACCOUNTABLE CARE ORGANIZATIONS

---

## ACO Requirements

“...An ACO shall meet the following requirements:

- “...be willing to become accountable for the quality, cost, and overall care of the Medicare *fee-for-service* beneficiaries assigned to it.



## ACCOUNTABLE CARE ORGANIZATIONS

---

“...The ACO shall

- enter into at least a 3 year agreement...
- “...a *formal legal structure* that would allow the organization to receive and distribute payments for shared savings...
- “...include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries (at least 5000)...



## ACCOUNTABLE CARE ORGANIZATIONS

---

- *“...define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies....”*
- *“...demonstrate...that it meets patient-centeredness criteria...”*



# ACCOUNTABLE CARE ORGANIZATIONS

---

## Payments For Shared Savings

“Subject to performance with respect to the quality performance standards..., if an ACO meets the requirements..., a percent...of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program...”

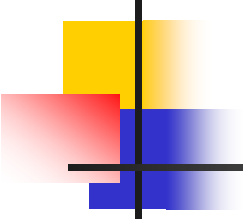


# PHYSICIAN-HOSPITAL AFFILIATION INITIATIVES

---

There is no “one size fits all” solution

- Creating an “integrated culture” among providers will be critical
  - Trust and shared values
  - Key benchmarks:
    - Patient-centered care
    - Quality outcomes
    - Value



CALIFORNIA PHYSICIAN-HOSPITAL  
AFFILIATION INITIATIVES

---

“Form follows function.”

- Frank Lloyd Wright

Mr. Wright was right!



# CAPITATED MEDICAL GROUP

---

Natural expansion of capitated medical groups as ACOs

- “Out of the Box” potential for rapid hospital/ACO joint venture arrangements
- Existing primary care and specialists provider agreements
- Existing agreements with hospitals
- Existing QI, UR, informatics and payment systems
- Payer contracting and medical management know-how



## IPA NETWORK MODELS

---

Natural expansion of capitated IPAs as Medicare ACOs

- “Out of the Box” potential for rapid hospital/ACO Medicare joint venture arrangements
- Existing primary care and specialists provider agreements
- Existing agreements with hospitals
- Existing QI, UR, informatics and payment systems
- Payer contracting and medical management know-how



## IPA NETWORK MODELS

---

IPAs must create meaningful clinical integration between/among providers in order to expand fee-for-service product line from Medicare to commercial payers

- Commercial payers are eager to expand into the budding ACO market
- Unlike Medicare that sets the contractual rate and determines the shared savings, IPAs will be required to negotiate fee-for-service compensation with commercial insurers
- While antitrust guidelines allow FFS price negotiations, the current clinical integration guidelines are fairly arduous for networks to achieve



## PARTNERSHIP/JOINT VENTURE MODEL

---

- Creation of a JV between hospital and physicians
  - JV provides formal legal structure to receive/distribute payment
  - Payments continue to be made to JV participating providers for services under original Medicare FFS Part A and Part B
  - Can JV serve as the platform for bundled service initiatives and gainsharing?



## JOINT VENTURE MODEL

---

Participants in JV “work together to manage and coordinate care” of Medicare fee-for service patients

- Quality benchmarks
- Evidence-based medicine
- Cost measures



# MEDICAL FOUNDATION MODEL

---

- Stringent statutory requirements, including
  - tax exemption
  - medical research
  - health education
  - 40 physicians covering at least 10 medical specialties, 2/3 of whom practice full time at clinic
- History of Foundations



# MEDICAL FOUNDATIONS

---

## Physician Compensation

- Today, productivity is the key component
- In the future, will productivity remain the key component?
  - Quality outcomes
  - Value
  - Citizenship
  - Other factors, *e.g.* managing the cost of care



## MEDICAL FOUNDATIONS

---

- Should physicians share financial risk?
- How do new foundations foster “culture” and “shared values”?



# MEDICAL FOUNDATIONS

---

- Medical Foundation Governance
  - Should the Medical Foundation entity should be a distinct, separate 501(c)(3) entity from the hospital/health system?
  - Board oversight of the Medical Foundation's clinical platform and contracts with physicians and payers requires both expertise and time
  - Substantial physician leadership on governing board is critical
  - Physicians should occupy key management and medico-administrative positions



# MEDICAL FOUNDATIONS

---

- Medical Foundation Reality Check
  - Is it just a “work around” the corporate practice prohibition where physicians only “show up” for work?
  - Is it just a way to try to maintain hospital margins and markets for as long as it can?



# MEDICAL FOUNDATIONS

---

- Medical Foundation Reality Check
  - Is it a hospital/physician integration platform among *strategic partners* who have shared values?
  - Is the Medical Foundation dedicated to providing accountable care as to both quality and price?
  - Is it a vehicle where innovation is encouraged, valued and rewarded?



## ACA: BUNDLING OF SERVICES

---

- Medicare will likely expand the use of global payments to create economic incentives for hospital-physician alignment
- Easily adaptable to elective surgery



## BUNDLING OF SERVICES

---

- Ten (10) conditions (selected by Secretary) to be implemented by January 1, 2013
- Global payments will force hospitals and physicians to create clinical protocols and modify operating systems in order to deliver medical services more efficiently



## BUNDLING OF SERVICES

---

- Looming battles over the division of money between and among providers
- Common informatics (HITECH) will be indispensable for clinical integration and remain a multi-year, expensive undertaking



## HEALTH REFORM

---

- Regulations from HHS: *Waiting for Godot?* (HHS has a lot on its plate!)
- Legal issues in organization and operation of ACOs
- Ownership succession issues



## CONCLUSIONS

---

- A. Each market will require existing providers to collaborate on how best to respond to change
- B. Shared values and “partnering” will be critical under any ACO/JV model
- C. Goals of the participating providers should drive the choice of the ACO model

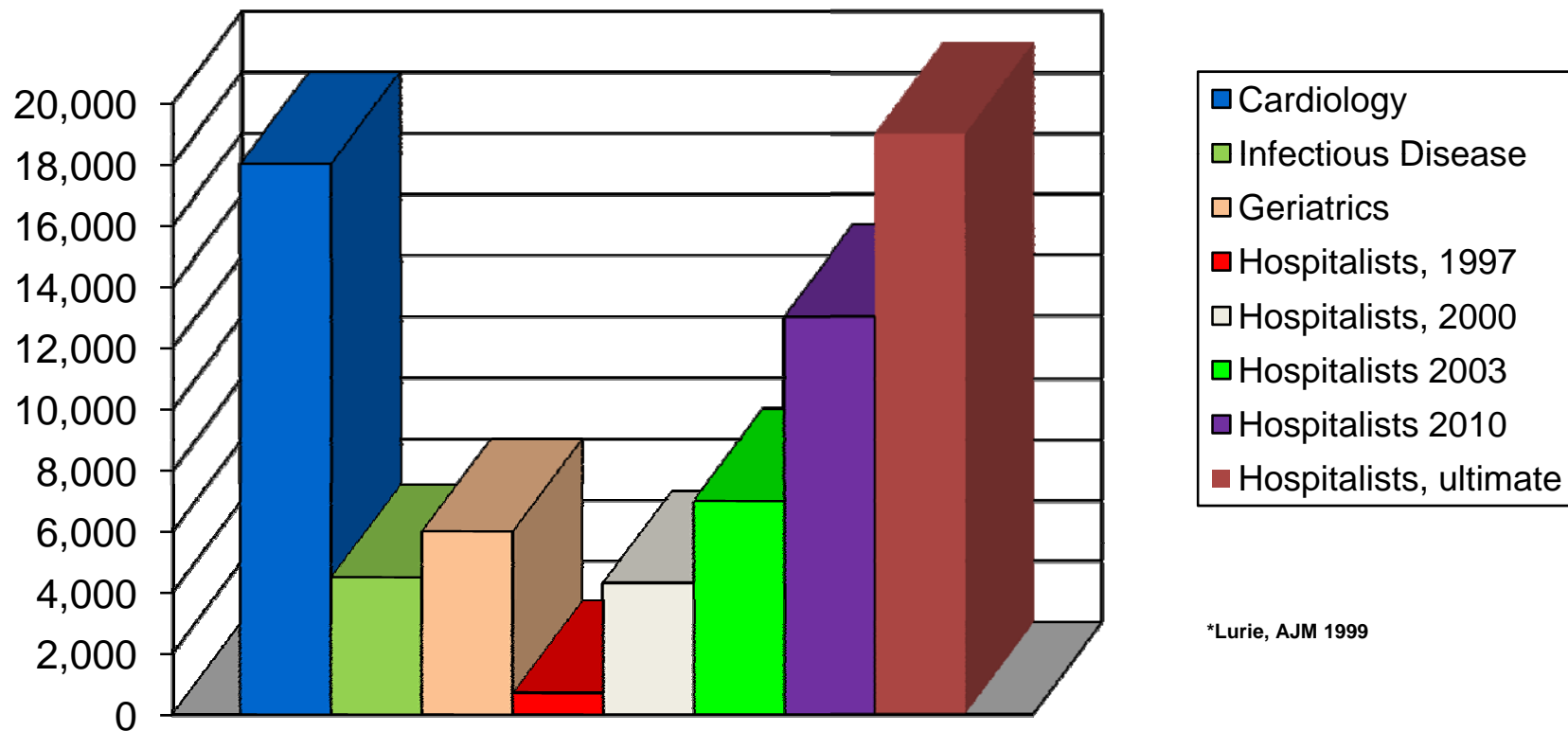
# Hospital Medicine in California 2010

Andrew Auerbach MD MPH  
Associate Professor of Medicine in Residence  
UCSF Division of Hospital Medicine  
[ada@medicine.ucsf.edu](mailto:ada@medicine.ucsf.edu)

# Introduction

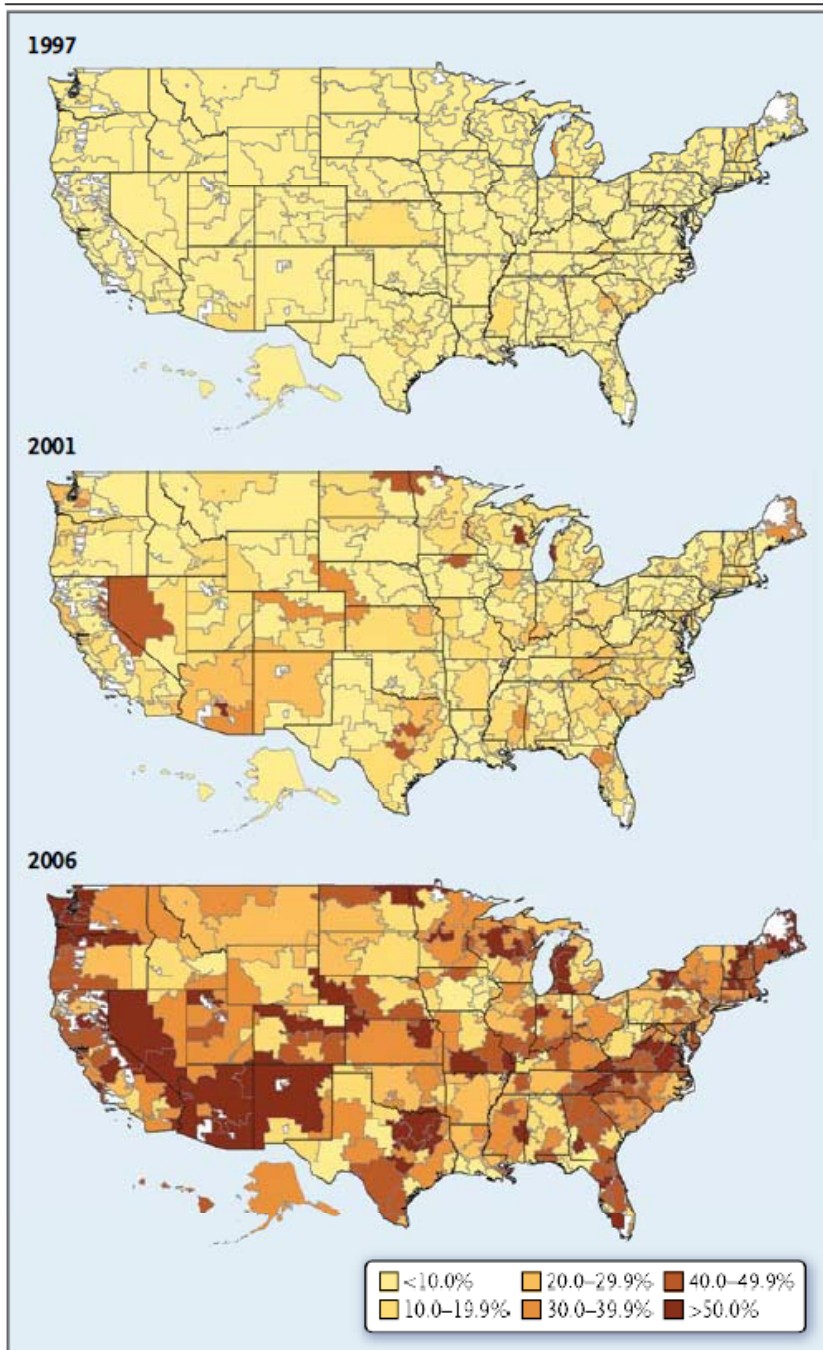
1. Overview of current evidence describing the effects of hospitalist systems
2. Hospitalists in California
3. Key questions for Hospitalists in 2010
4. Time for questions

# The hospitalist movement



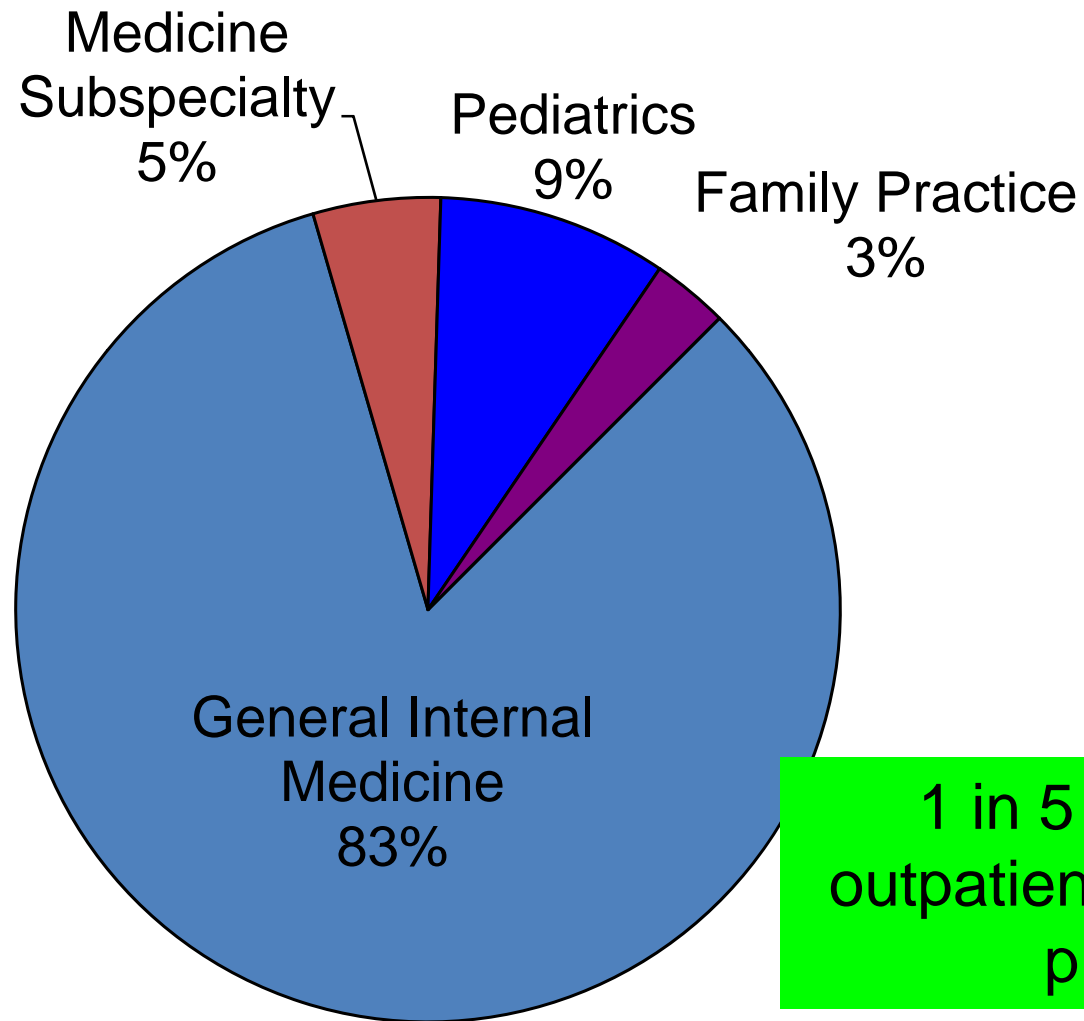
\*Lurie, AJM 1999

# Use of Hospitalists in US 1997-2006



- Average growth rate of 29% per year among Medicare beneficiaries
- Current use ranges from 20 to 80% of Medicare beneficiaries
- Pacific region no more likely to have adopted than other areas

# Where do hospitalists come from?

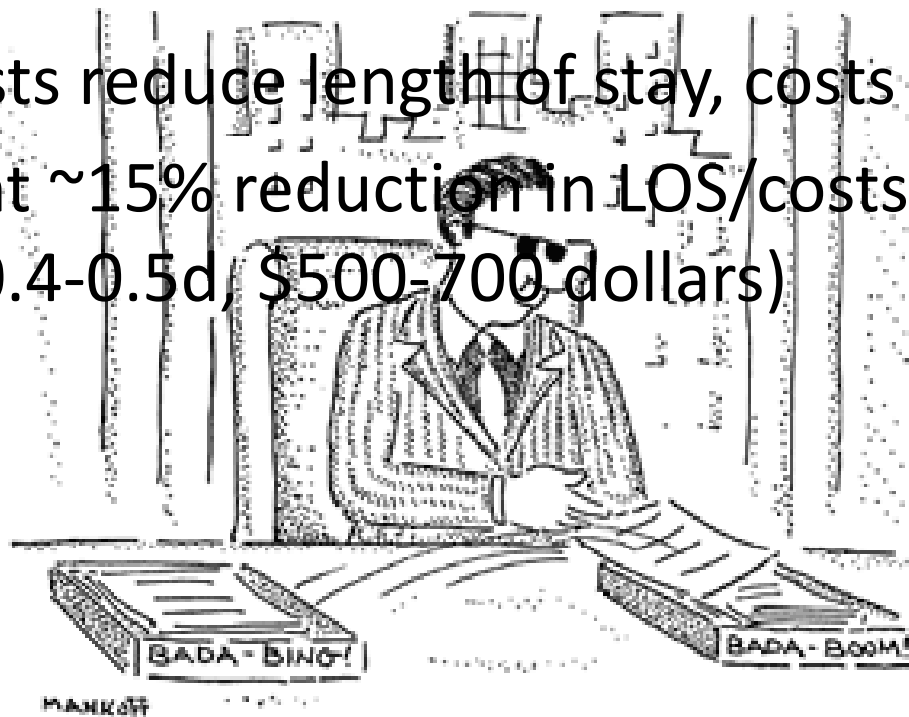


# Hospitalists = inpatient generalists

- Other observations
  - Most have been hospitalists for <10 years
  - Most say they want to keep doing it, at least for the next 3-4 years

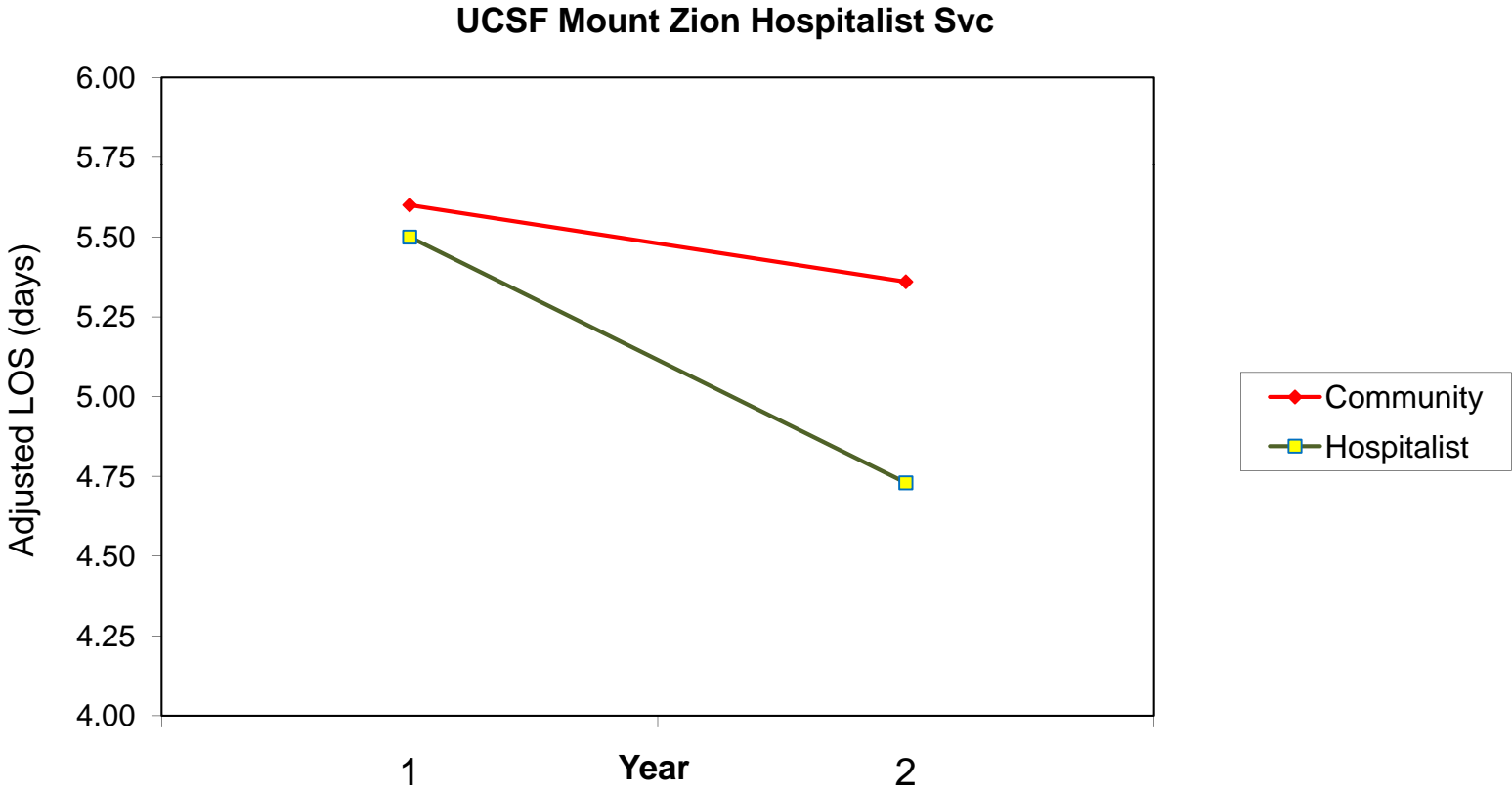
# Evidence for hospitalists

- Early Evidence:
  - Hospitalists reduce length of stay, costs
  - Consistent ~15% reduction in LOS/costs across studies (0.4-0.5d, \$500-700 dollars)



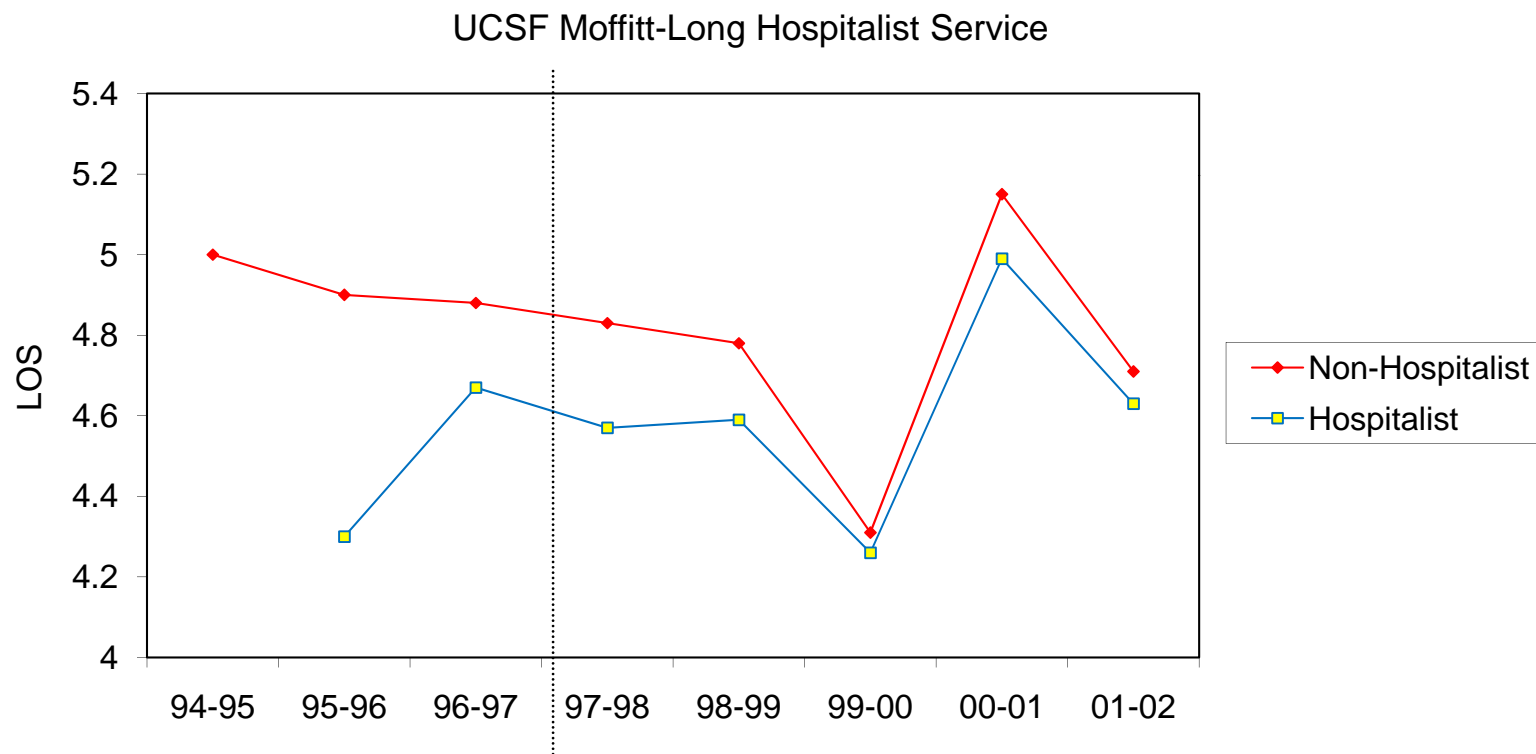
It's no longer quite that simple...

# Efficiency and the learning curve



**p for trend in hospitalist LOS = 0.002**  
**p for trend in community LOS = 0.17**

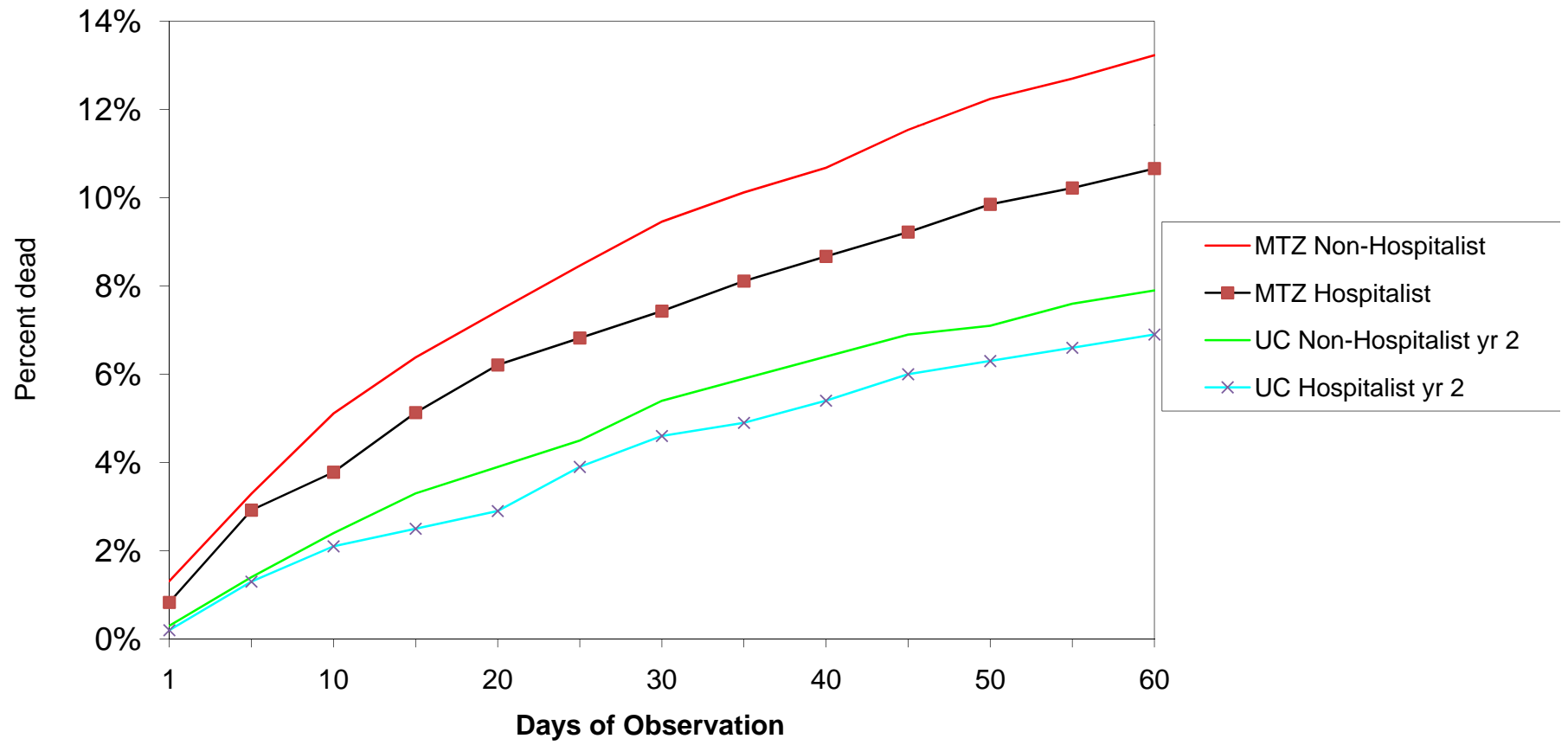
# Efficiency over time



# Efficiency savings disappear

- LOS/Cost differences narrow over time
  - Initial system inefficiencies are the easiest to overcome
  - Other systems are implemented (e.g. case management)
  - Non-hospitalist group selects for the most experienced/busiest doctors
  - Hospitalist burnout/turnover

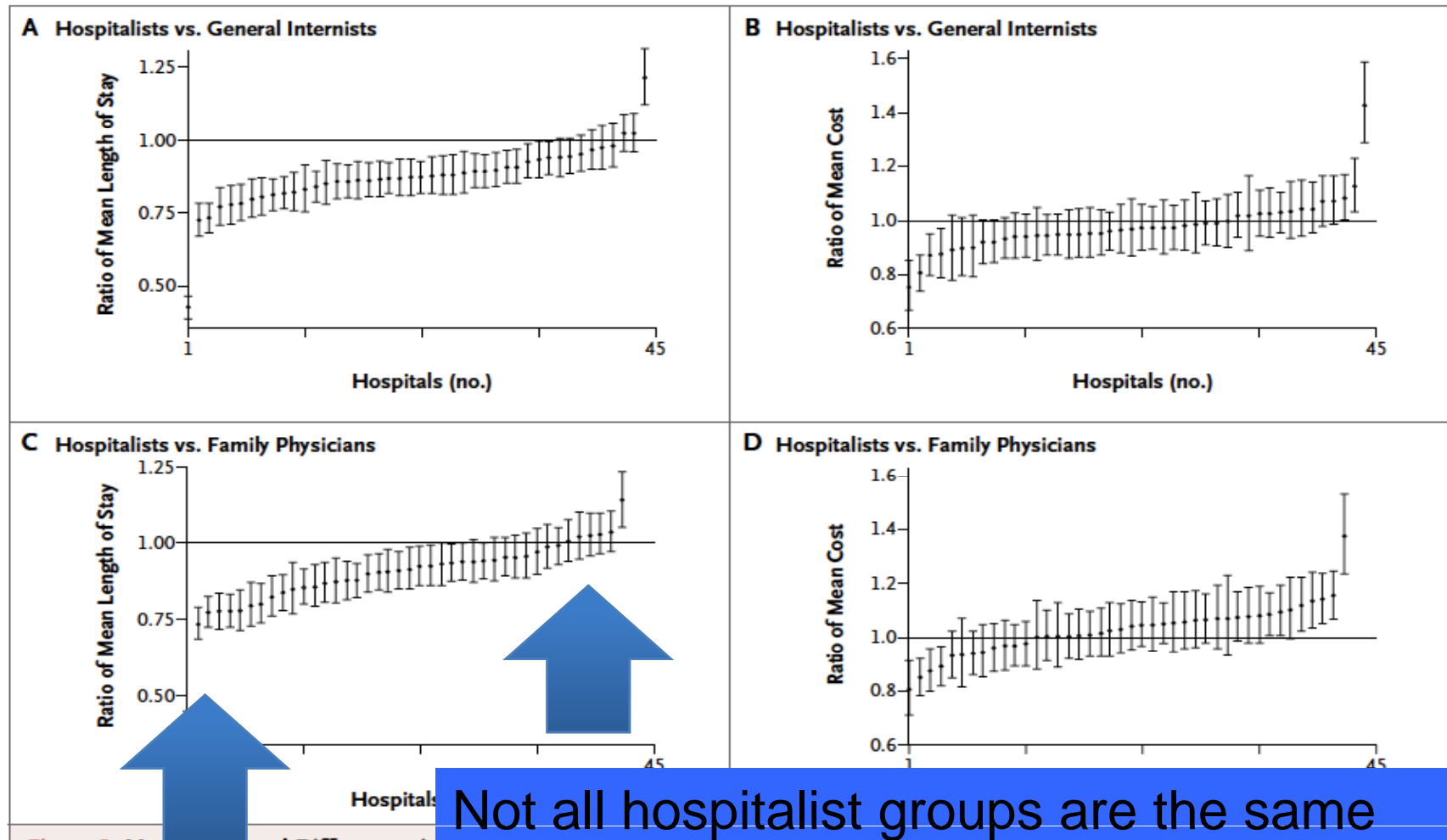
# Do hospitalists reduce mortality?



# Major multisite study of hospitalists

- Study question:
  - Do hospitalists provide more effective and less expensive care? (Lindenauer, NEJM 2007)
- Comparison of hospital medicine (hospitalist) physician care to internists to family medicine
- 45 Hospitals, ~60,000 patients
- Summary of results:
  - Hospitalists provided care that was generally shorter LOS
  - Had similar cost, mortality, similar readmission rate

# Hospital medicine systems



**Figure 2. Model-Adjusted Differences in the Length of Hospital Stay and Cost among Patients Cared for by Hospitalists, General Internists, and Family Physicians.**

Panel A shows differences in the length of stay and Panel B shows differences in cost for patients cared for by hospitalists and general internists. Panel C shows differences in the length of stay and Panel D shows differences in cost for patients cared for by hospitalists and family physicians. CI denotes confidence interval, and I bars denote 95% confidence intervals.

# Physician satisfaction

Referring physician 1996:

“Just don’t make me”

“This will kill Medicine”

“I’ll move to Canada”

# Physician satisfaction

- Referring physician 2000:
  - Survey of 240 physicians at an academic center in Boston 2y after hospitalist service implemented
  - 60% had also responded to a similar survey before the service 'went live'
  - About 50% were PCP's

# Physician satisfaction

<u>Question</u>	<u>Trend 1998-2000</u>
● Caring for inpatients an inefficient use of my time	More agreement
● Caring for inpatients best directed by PCP ● Hospitalists damage PCP-pt relationship	More <u>disagreement</u> to both
● Hospitalists improve quality of care ● Hospitalists lower costs	More agreement to both
● Hospitalists reduce PCP income	More agreement

# Evidence for quality

- CHF:
  - Shorter LOS, more frequent use of echocardiography with hospitalists (Lindenauer, Arch Int Med 2002)
  - No difference in performance on CMS core measures (Vasilevskis, JGIM 2009)
- Pneumonia:
  - Greater adherence to pneumonia pathway (Reddy, AM J Man Care 2001)
  - More frequent discharge before clinically stable (Brotman, AJM 2003)
  - Slightly higher performance on selected CMS measures (e.g. vaccination) (Vasilevskis, JHM 2009)
- Palliative care:
  - More frequent documented discussions with patients
  - More frequent use of effective palliative care therapies
  - Fewer distressing symptoms at the end of life (Auerbach, AJM 2003)

# Evidence

- Readmission:
  - No effect on readmission in any study to date
- Patient Satisfaction
  - No effect – but most data are from academic sites

# Summary of evidence for hospitalists

- Field is growing rapidly, and remains fairly young
- Initial impact on costs, length of stay, and outcomes likely not sustained
- Little evidence for improvements in quality
- No evidence for harm to patients

# Hospitalists in California

- Issue Brief – Published online July, 2007
- 2 steps:
  - Surveys of hospitals and hospitalists
  - Focus groups with hospital leaders and physician practice groups

<http://www.chcf.org/topics/hospitals/index.cfm?itemID=133365>



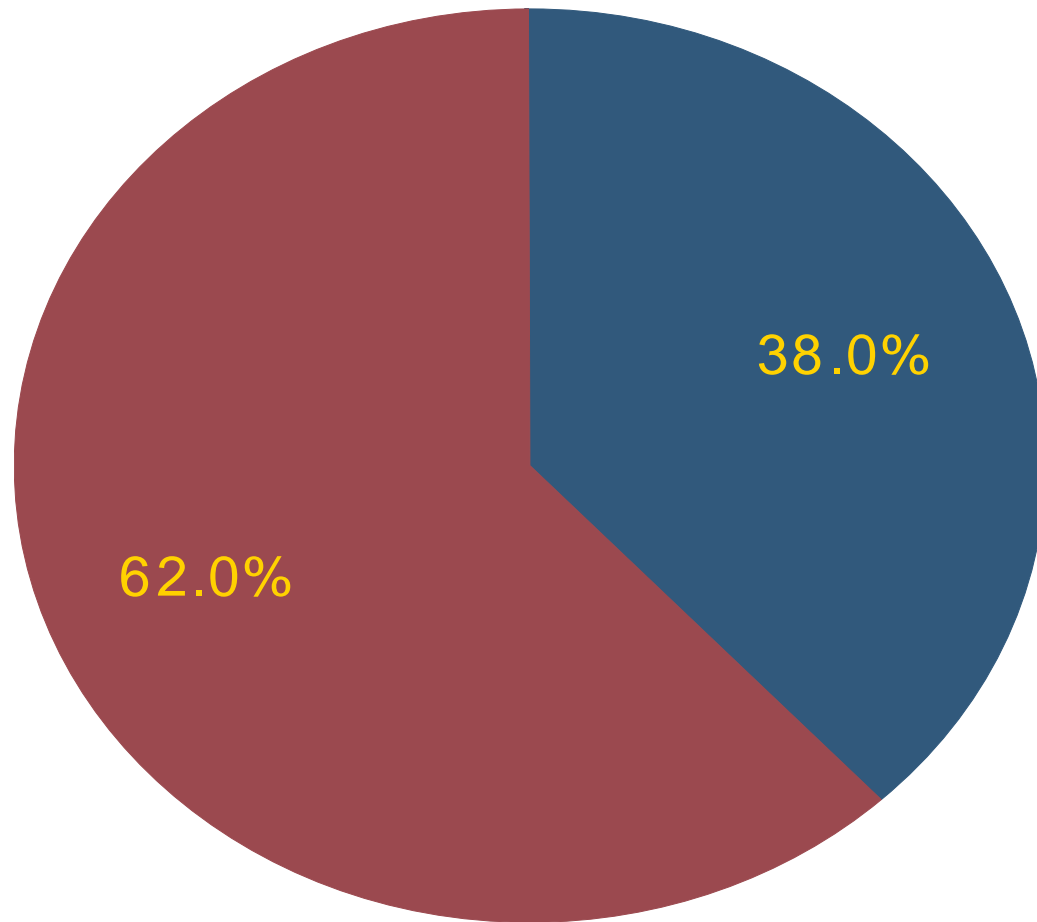
## The Rise of the Hospitalist in California

July 2007

# Characterizing hospitalists' practice – California statewide survey

- Survey of 331 non-federal acute care hospitals in California
- 2 target recipients:
  - Hospital 'C' suite –
    - Specifically, someone who would know whether or not the hospital had a hospitalist group
    - Someone who could answer questions related to the hospital's quality initiatives and challenges
  - Hospitalist group leader

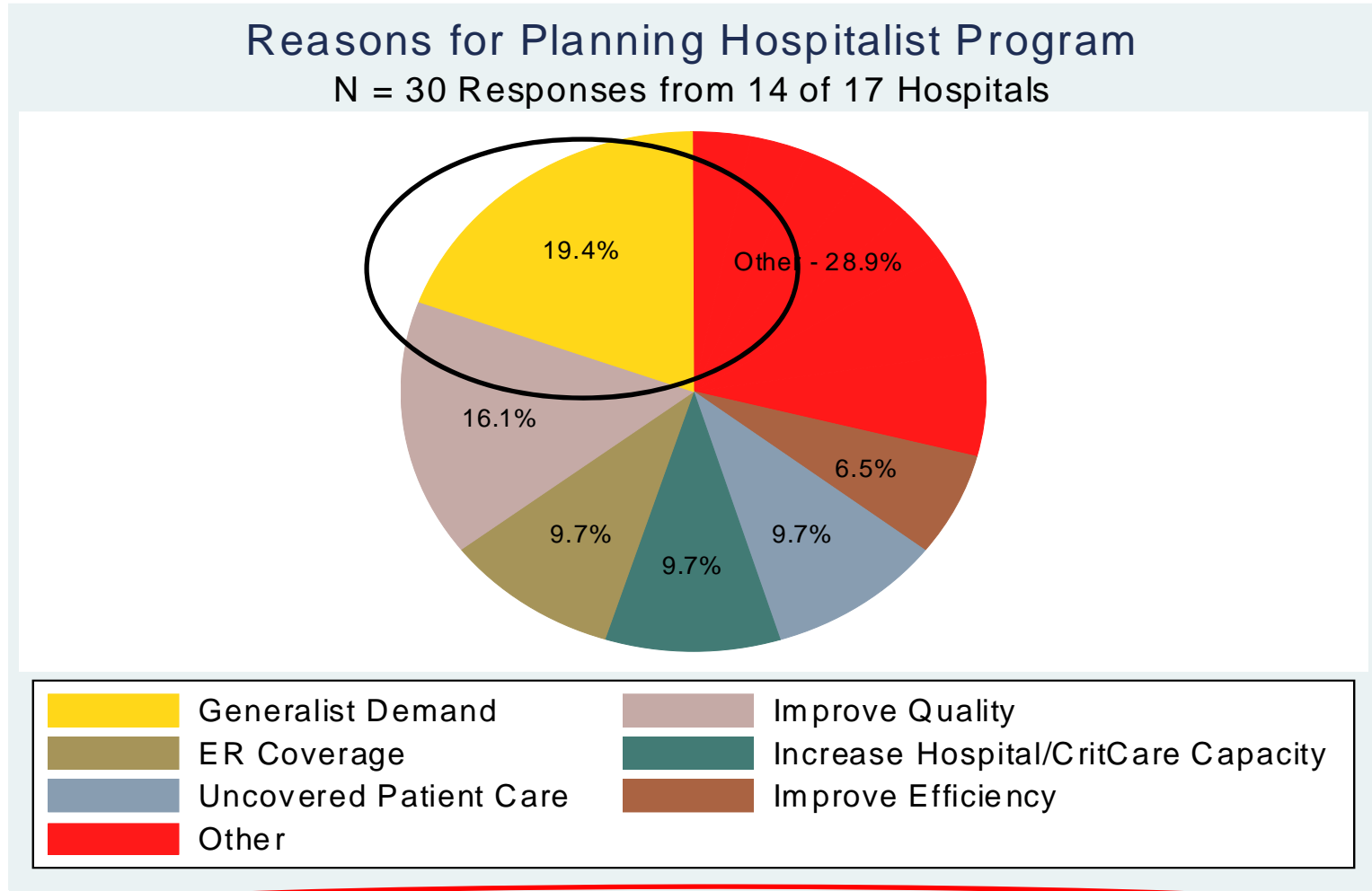
## Percent of Respondent Hospitals with Hospitalists



# Why did you start a hospitalist group?

	<u>%</u>
Take Care of Uncovered Patients	73%
To Improve ER Efficiency	64%
Decrease Length of Stay	61%
To Decrease Costs	52%
Demand by Primary Care Groups	39%
Improve Patient Satisfaction	33%
ER Coverage	30%
Improve Quality of Care	30%
Demand by Specialist Groups	23%
24h coverage of patients	20%
Surgical Co-Management	16%

# Why are hospitals thinking about starting a hospitalist program?

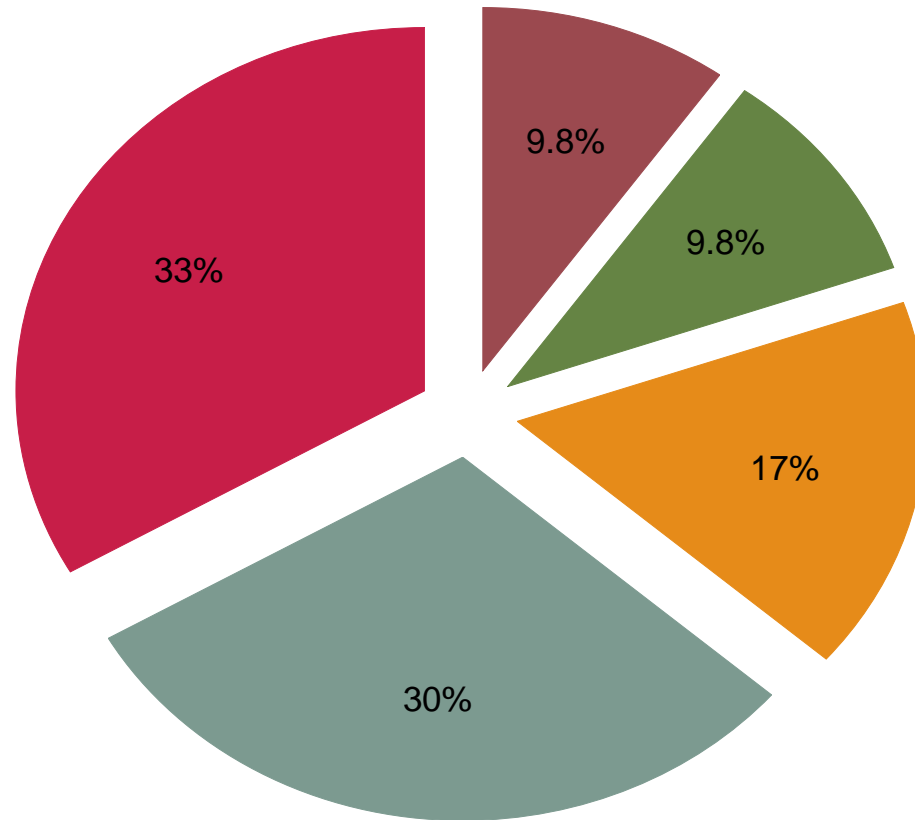


Other: Surgical Co-Management (3.2%), Specialist Demand (6.4%), Improve Physician Satisfaction (3.2%), 24 Hour Coverage (6.5%), Improve Efficiency (6.5%), Decrease Costs(6.5%), Improve ER Efficiency (3.2%)

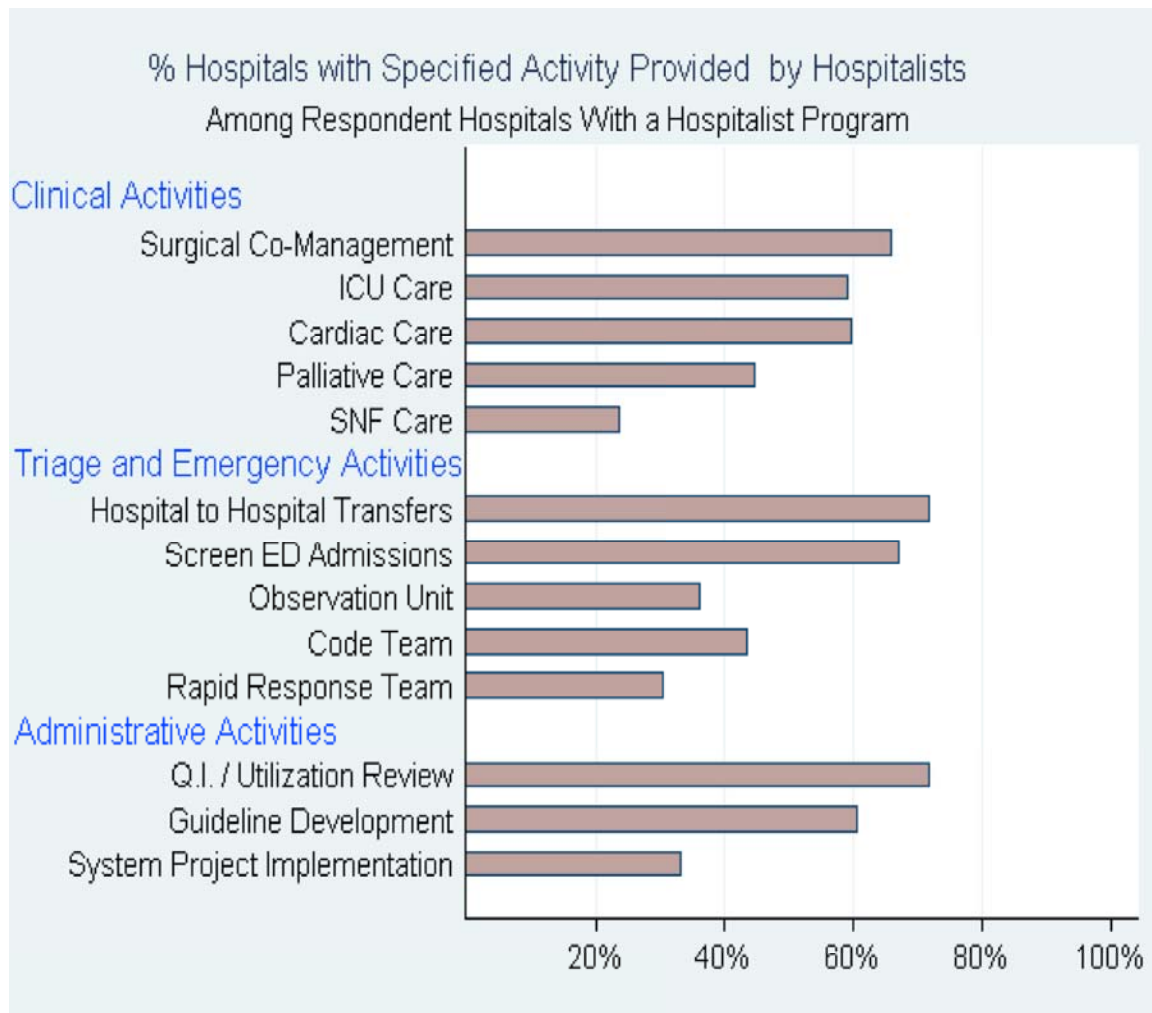
# Characteristics of hospitals with and without hospitalists

<u>Variable</u>	<u>With Hospitalists</u> <u>N, % (N = 115)</u>	<u>Without Hospitalists</u> <u>N, % (N = 64)</u>	<u>p-value</u>
Hospital size, Beds			
0-99	18 (35.3)	33 (64.7)	<0.01
100-199	32 (62.8)	19 (37.3)	
200-299	23 (82.1)	5 (17.9)	
300+	42 (85.7)	7 (14.3)	
Hospital Type			
City/County	7 (46.7)	8 (53.3)	0.12
For-Profit	16 (61.5)	10 (38.5)	<0.01
Teaching Hospital	30 (79.0)	8 (21.1)	0.03

# Who employs the hospitalists?



# California hospitalists' activities



# Survey results - summary

- Not surprisingly, field is growing
  - Diversity of roles in the hospital, clinical and non-clinical
- From 2000-2008
  - More hospitals said they started hospitalist programs to address quality and safety
  - Costs, length of stay, throughput needs remained high importance, but 24 hour coverage also key
  - Major demand for hospitalists is coming from other physicians

# Focus group findings:

- Increasing reliance on hospitalists to assume a growing number of clinical as well as non-clinical roles.
  - Additional roles were facilitated because of hospitalists' availability, and because hospitalists' and hospitals' goals are aligned.
- Institutional quality initiatives (e.g. CMS measures, or EMR implementation)
  - Presence of hospitalists might improve measures, as well as facilitate implementation
- Intense focus on throughput and bed efficiency, particularly in ED waiting times
  - Hospitalists perceived as being the potential catalyst for changes.

# Focus group findings: Areas of current growth

- Surgical co-management:
  - Though likely to improve quality, at costs of having surgeons even more removed from daily patient care and their hospital.
  - Concern that surgical co-management might harm hospitalist morale and job satisfaction.
- Supervision of allied healthcare providers (e.g. nurse practitioners, physician assistants):
  - The group felt that allied healthcare providers are currently playing a minimal role in California hospitalist groups, but that these providers were of keen interest as clinical roles expand.

# Critical issues

- Key challenges to funding hospitalist groups remain
  - Stagnant Medicare reimbursements
  - Increasing numbers of uncovered patients
  - High competition for hospitalists' services is further increasing costs of supporting hospitalists.
- Demand for hospitalists is high
  - Mobility, and growing needs leading to rapid salary rises.
- Some hospitalists maintain high encounter rates (20+ inpatients/day).
  - High workload is financially attractive but contributes to burnout and may compromise efficiency advantages
  - Increasing diversity of clinical and non-clinical duties between hospitals creates new opportunities as well as potential hardships.
- High turnover rates – as high as  $\frac{1}{4}$  of the workforce changing jobs annually

# Critical issues

- There is significant variation in the hospitalists' training level, as well as how hospitalist groups are managed.
  - Group felt strongly that there was a need to “better define hospitalist roles and set clear expectations when contracts are negotiated”
  - Matching hospitals' clinical needs to hospitalists' training and expertise critical.
  - “Systems competencies,” quality improvement, safety, and information technology crucial.
- Transitioning patients between hospitalists and primary care physicians remains a concern
  - Gaps in the post-discharge period can lead to emergency department and inpatient readmissions
  - Harm relationships with primary care and sub-specialist physicians.

# California Hospitalists

- Focus group findings – summary
  - Increasing reliance on hospitalists leading improvements within the hospital
  - Real concerns about the sustainability of the job, turnover, and training
  - Real concerns about maintaining handoffs, community and referring physician relationships

# Critical questions for hospitalists 2010

# The hand-off

- Major issues for Longitudinal/Primary care physicians:
  - Not being informed of patient admission
  - Not having input into important decisions during hospitalization
  - Poor coordination of care at discharge (e.g. followup apts)

# The hand-off

- Major issues for Hospitalists:
  - Not being able to get salient elements of PMHx, psychosocial history at admission
  - No longterm context useful for assessing psychosocial needs
  - Limited ability to ‘add on’ or speed followup after discharge, and (often) limited ability to provide followup personally

# The hand-off

- Shared issues identified (bi-directional):
  - Lack of phone numbers
  - Non-secured emails
  - No clear systems for noting that a communication was received
  - Everyone is extraordinarily busy

# Handoff

- Some solutions:
  - Mandatory phone call at admission by ED/Hospitalist
  - Standard email notification completed by resident with 'receive receipt'
  - Monthly surveys of referring physicians to monitor satisfaction, and address outlying hospitalists
  - Hard stop in registration system which requires PMD to be notified at time of pt admission
    - PMD's must have up to date contact numbers in order to participate
  - There are no perfect systems .... EHR is a great hope

# Discharge communication

- Medicolegally, hospitalist is responsible until first visit with PCP
  - Standards for communication at discharge
    - Discharge summary
    - Emailed or faxed notes
    - Telephone call
    - PCP visit in hospital
  - No consistent 'expectation' at national level, though several projects say DC summary <24h

# Discharge communication

- Programs focused on improving discharge coordination are TNTC
  - Many are being led by hospitalists
    - Discharge coaches
    - 24-72 hour followup calls, care pathways for high utilization diseases (e.g. CHF)
    - Standardized discharge summaries
    - Variety of systems to automate discharge communication
      - E-discharge summaries, automatically faxed discharge summaries

# Discharge communication

- Same lesions exist at discharge
  - Logistically difficult to have face to face discussions, or even phone calls
  - Electronic medical records do not yet provide a real solution

# The hospital/clinic chasm

- Fewer longitudinal MDs are coming to the hospital
  - <20% of admissions to UCSF are to non-hospitalists
  - At community hospitals
    - More PCP's remain engaged but trend is also toward more frequent use of hospitalists, even in 'open' systems
    - More pressures on clinic productivity
    - Teaching hospitals – increasing restrictions on resident duty-hours increasing need for inpatient presence
  - Increasing focus on competence in clinical roles to support granting credentials

# Healing the Hospital/clinic chasm

- You realize this is a huge problem
- Your hospitals realize this is a huge problem
- Your hospitalist colleagues realize this is a huge problem

# Healing the Hospital/clinic chasm

- Systems which do this well have a few characteristics:
  - Financially support roles for community based physicians in hospital operations (quality, medical staff board).
  - Include hospitalists in medical staff operations
  - Ensure that hospitalists' contracts include expectations for communication
  - Create systems which facilitate and track effective communication
  - **No 'mandatory' hospitalist systems**

# Solution, or another problem

- Will new payment models force the chasm to close?
  - Accountable care organizations
  - Bundled care payments

# Conclusions

- Hospitalists are the major providers of hospital care in the U.S.
  - Initial demand based on cost savings cannot be sustained
  - Current demand is based on
    - Need for operational roles
    - Need to address new workforce problems
    - Meet needs of a variety of physician groups.
- Improving handoffs and transitions is a shared goal
  - Leverage that realization and the emergence of new payment models to achieve that end

# Conclusions

- Effective systems must overcome the limitations inherent to hospital medicine systems
  - These are models which are sustainable
  - These are the models which are best for patients
  - Hospitalists know this, and are eager for partnership