

Beth Israel Deaconess Medical Center

Harvard Medical School Teaching Affiliate

Hospitalist System in USA: Cornerstone for a Successful Hospitalist System in Korea

Korean Association of Internal Medicine
67th Annual Scientific Congress

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Disclosures

- Employer: Harvard Medical Faculty Physicians at BIDMC
- American Board of Internal Medicine Hospital Medicine Maintenance of Certification Exam Writing Committee member
- American College of Physicians Board of Regents member
- Elsevier Hospital Medicine Clinics Editor
- Journal of Hospital Medicine Editorial Board Member
- Society of Hospital Medicine Past President
- WebMD / Medscape Internal Medicine & Hospital Medicine Editorial Board member



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Learning Objectives

- Describe the development and growth of hospital medicine in the US
- Understand the forces which drove the development of the hospitalist model in the United States
- Discuss the impact of hospitalists on medical education and care of hospitalized patients
- Highlight critical issues necessary to the success of developing a hospitalist model of care



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The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Zero to 50,000 — The 20th Anniversary of the Hospitalist

Robert M. Wachter, M.D., and Lee Goldman, M.D., M.P.H.

Twenty years ago, we described the emergence of a new type of specialist that we called a "hospitalist."[1] Since then, the number of hospitalists has grown from a few hundred to more

sion and often multiple daily visits during hospitalization, regardless of whether that disrupted the flow of physicians' outpatient practices. Moreover, the remuneration for

Description of hospital medicine in USA: 1996

Wachter RM, Goldman L.

"The Emerging Role of "Hospitalists"

in the American

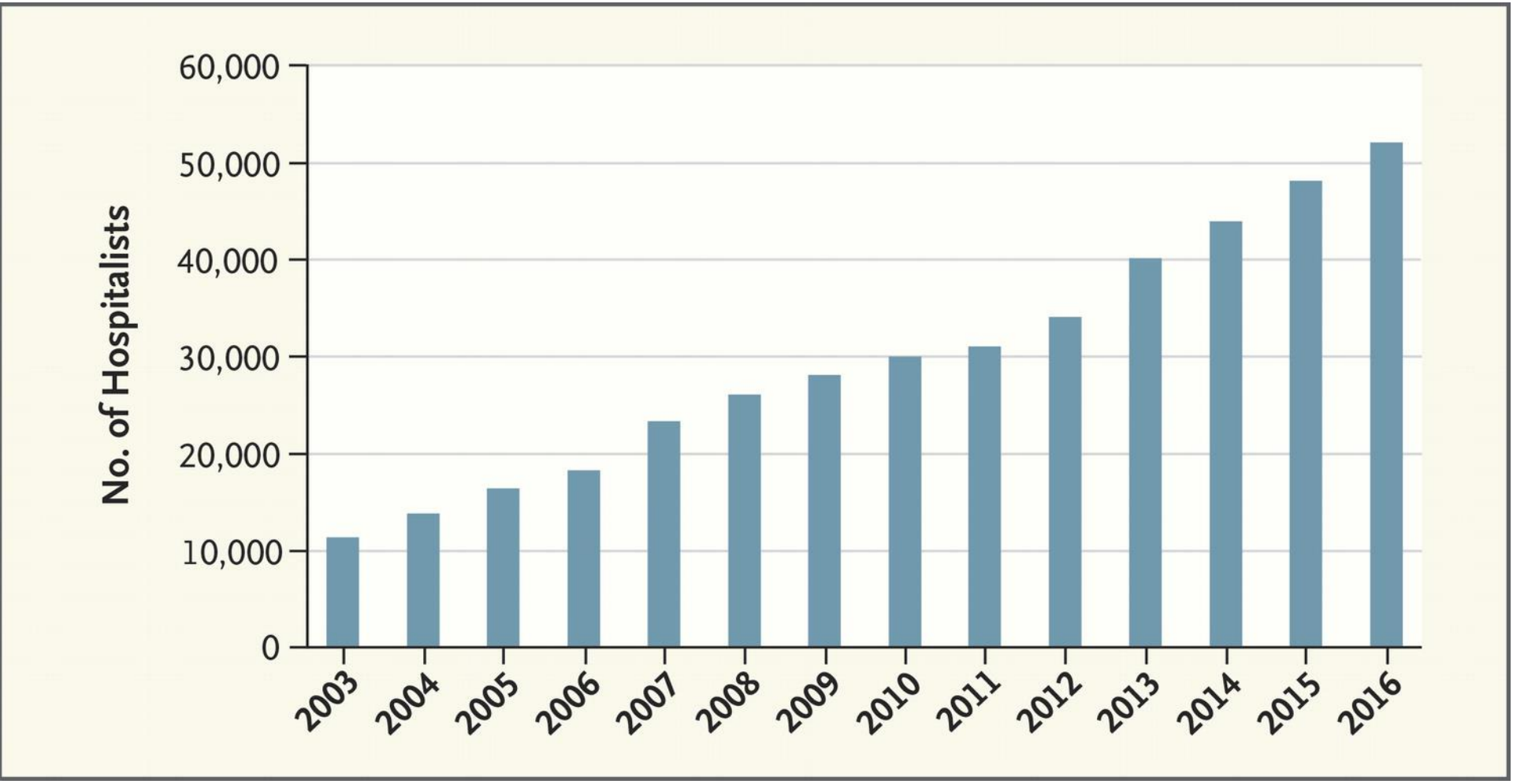
Health Care System.

NEJM Vol 335:514-517

Aug 15, 1996


The New England Journal of Medicine

Number of hospitalists in USA



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- Harvard Medical School
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Beth Israel Deaconess Hospital Medicine: July 1998



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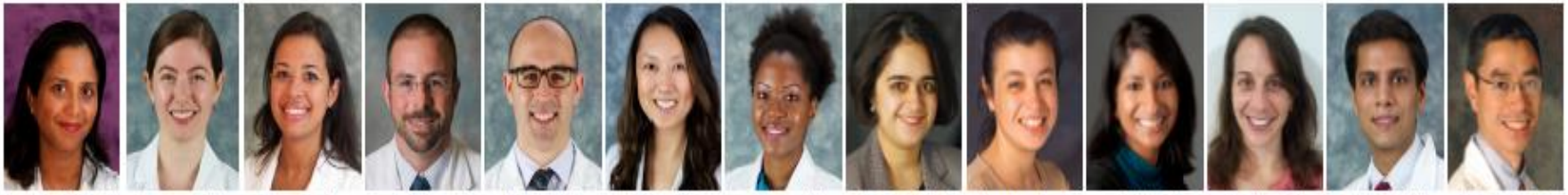
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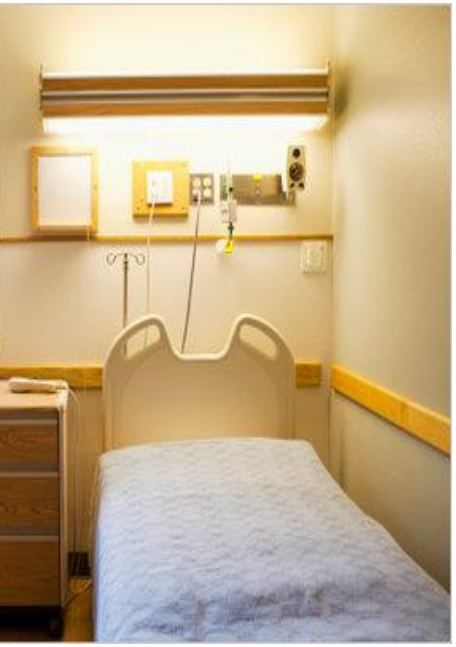
Julius Yang, MD, PhD

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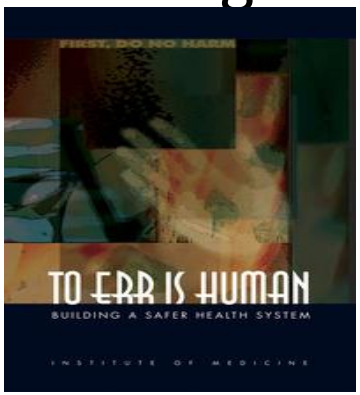




RehabCenter.

Forces which shaped the development of hospital medicine in the USA

- Unsustainable primary care physician job description
- The need for a inpatient generalist given the increasing complexity of an aging population
- Demand for higher value care (value = quality / cost)
- Workforce demands related to change in physician training



ACGME



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Issues to address when developing a hospitalist model of care

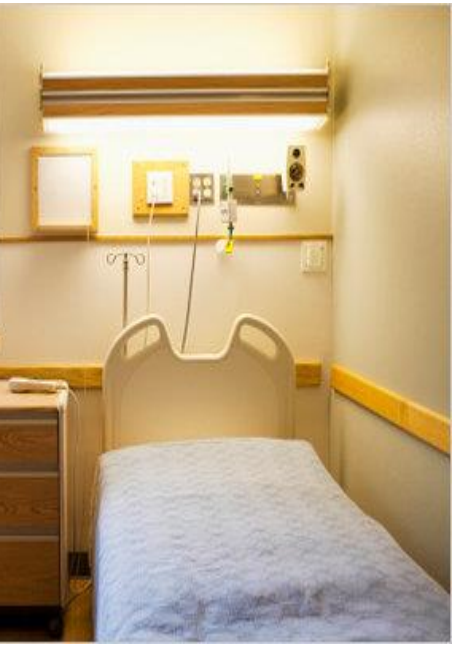
- Focus on transitions of care
- Be wary of fragmentation of care in a system w fragmented clinical information systems
- Understand that pts choose their outpatient doctors but not their hospitalists
- Who will hospitalists replace? Who are the potential winners & losers in this re-organization of care?
- The opportunity and demand for team-based care
- Create a sustainable job description

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Rates of Medical Errors and Preventable Adverse Events Among Hospitalized Children Following Implementation of a Resident Handoff Bundle

Amy J. Starmer, MD, MPH; Theodore C. Sectish, MD; Dennis W. Simon, MD; Carol Keohane, RN; Maireade E. McSweeney, MD, MPH; Erica Y. Chung, MD; Catherine S. Yoon, MS; Stuart R. Lipsitz, PhD; Ari J. Wassner, MD; Marvin B. Harper, MD; Christopher P. Landrigan, MD, MPH

OBJECTIVE To determine whether introduction of a multifaceted handoff program was associated with reduced rates of medical errors and preventable adverse events, fewer omissions of key data in written handoffs, improved verbal handoffs, and changes in resident-physician workflow.

DESIGN, SETTING, AND PARTICIPANTS Prospective intervention study of 1255 patient admissions (642 before and 613 after the intervention) involving 84 resident physicians (42 before and 42 after the intervention) from July-September 2009 and November 2009-January 2010 on 2 inpatient units at Boston Children's Hospital.



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INTERVENTIONS Resident handoff bundle, consisting of standardized communication and handoff training, a verbal mnemonic, and a new team handoff structure. On one unit, a computerized handoff tool linked to the electronic medical record was introduced.

MAIN OUTCOMES AND MEASURES The primary outcomes were the rates of medical errors and preventable adverse events measured by daily systematic surveillance. The secondary outcomes were omissions in the printed handoff document and resident time-motion activity.



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RESULTS Medical errors decreased from 33.8 per 100 admissions (95% CI, 27.3-40.3) to 18.3 per 100 admissions (95% CI, 14.7-21.9; $P < .001$), and preventable adverse events decreased from 3.3 per 100 admissions (95% CI, 1.7-4.8) to 1.5 (95% CI, 0.51-2.4) per 100 admissions ($P = .04$) following the intervention. There were fewer omissions of key handoff elements on printed handoff documents, especially on the unit that received the computerized handoff tool (significant reductions of omissions in 11 of 14 categories with computerized tool; significant reductions in 2 of 14 categories without computerized tool). Physicians spent a greater percentage of time in a 24-hour period at the patient bedside after the intervention (8.3%; 95% CI 7.1%-9.8%) vs 10.6% (95% CI, 9.2%-12.2%; $P = .03$). The average duration of verbal handoffs per patient did not change. Verbal handoffs were more likely to occur in a quiet location (33.3%; 95% CI, 14.5%-52.2% vs 67.9%; 95% CI, 50.6%-85.2%; $P = .03$) and private location (50.0%; 95% CI, 30%-70% vs 85.7%; 95% CI, 72.8%-98.7%; $P = .007$) after the intervention.

CONCLUSIONS AND RELEVANCE Implementation of a handoff bundle was associated with a significant reduction in medical errors and preventable adverse events among hospitalized children. Improvements in verbal and written handoff processes occurred, and resident workflow did not change adversely.



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