LEADERS: LORI HEIM, M.D.

AAFP President Charts Course as Hospitalist

Dr. Lori Heim is anything but a typical hospitalist. She came to the field after working for many years as a family physician in the outpatient arena, and she now enjoys the chance to focus on quality and have time for interests outside of her own practice. And when Dr. Heim isn't in the hospital, she's likely at the airport, on her way to another meeting with lawmakers or physicians to discuss health reform, workforce issues, or the Medicare payment formula. As the current president of the American Academy of Family Physicians, Dr. Heim brings a unique perspective to her Laurinburg, N.C., hospital.

Dr. Heim is the first family physician to join the new hospital medicine program at Scotland Memorial Hospital. Currently, she practices alongside four internists and two family nurse practitioners as part of the growing program. Nationwide, family physicians are a minority in the hospitalist community. The Society of Hospital Medicine reports that fewer than 4% of hospitalists are trained in family medicine, compared with more than 80% of practicing hospitalists who were trained in general internal medicine. Similarly, only about 4% of AAFP members were working as hospitalists in 2009. Whether that indicates a lack of interest by hospitals or family physicians is unclear. But Dr. Heim said hospital medicine can be a good option for family physicians, even if it's not a career-long choice.

For some, it's simply a love of hospital medicine that drives the career choice. For others, it may represent a chance to get away from the administrative issues that plague many family physicians in private practice. And it can a pragmatic way to get a better balance in their work and family lives. "What this shows is the incredible opportunity that [physicians] have within family medicine to tailor different parts of medicine, different focuses, at different times of their career," she said.

For their part, family physicians can bring additional skills to the hospital medicine world. For example, hospital medicine groups with family physicians can expand the care they provide to children. And Dr. Heim said that when she is called to a medicine consult with obstetric and gynecology patients, she is glad for her broad-based training. "I've dealt with a lot of the complications with regard to pregnancy and women's issues," she said. "It's very familiar territory given our training."

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DR. HEIM

Dr. Heim said her own experience as a hospitalist over the last 18 months has really opened her eyes to systemwide issues that can result in poor outcomes for patients. Although family physicians often do a good job during the face-to-face visit, there aren't good systems to help patients outside that encounter, she said. And patients who can't get an appointment to see their regular doctor, or who don't have a regular physician, often end up hospitalized or readmitted.

But Dr. Heim is using her position as AAFP president to draw attention to some of these gaps in care. She tells lawmakers and the media about her firsthand experiences in the hospital, highlighting how conditions that can be cheaply and easily treated in the primary care setting, such as hypertension, can become expensive complications by the time they reach her in the hospital.

After her official leadership role with AAFP wraps up in a few years, Dr. Heim said she hopes to bring some of the innovative solutions she's seen while traveling around the country back to her North Carolina hospital. She looks forward to taking concrete steps on concepts like the medical home neighborhood, which envisions more coordinated patient care with roles for the hospital, the hospitalist, the primary care physician, subspecialists, and the community. ■

By Mary Ellen Schneider

Hospitalists Can Take Leading Role In Health Care Reform Efforts

BY ALICIA AULT

NATIONAL HARBOR, MD. — Hospitalists should be feeling upbeat about the potential opportunities for their profession under the new health care reform law, several speakers said at the annual meeting of the Society of Hospital Medicine.

The law will give hospitalists a chance to show that they can provide cost-effective and efficient care, thus validating their specialty, speakers said at a plenary session that opened the meeting.

For instance, the law apparently will rely heavily on so-called "accountable care organizations" (ACOs), or groups of providers who pool their resources and efforts, and then receive a single payment for a patient's care. Although details are not yet available regarding the form that most ACOs will take, hospitalists "should be very excited" about this development, as they will have a leading role in helping such organizations to improve the quality and cost-effectiveness of care, said Dr. Ronald Greeno, cofounder and chief medical officer of Cogent Healthcare, a Brentwood, Tenn.–based hospital medicine management and consulting company.

Dr. Patrick Conway, a former pediatric hospitalist who is now chief medical officer at the Department of Health and Human Services, agreed that health care reform will give hospitalists a greater opportunity to make a difference because their experience in coordination of care will be even more crucial in the new landscape.

However, audience members expressed disappointment that malpractice liability reform was not addressed and that Congress did not replace Medicare's sustainable growth rate factor in either of the health reform bills passed—the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

In response to an attendee's question about personal accountability for health, Leslie Norwalk, former acting administrator of the Centers for Medicare and Medicaid Services under President George W. Bush, said that the law does place an important new emphasis on prevention and wellness, but that changing patients' health habits will be an uphill battle in a largely sedentary society.

Ms. Norwalk also predicted that comparative effectiveness research would rarely be used to guide care decisions, even if it yielded important findings.

In a plenary session that ended the meeting, Dr. Robert M. Wachter expressed a similar thought, saying that although the government has been—and will be—making a major investment in comparative effectiveness research, Medicare is forbidden from using the results to make coverage decisions. The United States is likely to become a major exporter of such research, joked Dr. Wachter, chief of the division of hospital medicine at the University of California, San Francisco.

He said that although the passage of health care reform was a remarkable political act, the legislation is designed to improve access to care and to reform the insurance market; many of the hard decisions about health care quality, cost, and safety are yet to be made.

Dr. Wachter said he is skeptical that ACOs could become widespread. A handful of ACOs, such as the Mayo Clinic and the Health System, are examples of how to integrate systems to provide high-value, high-quality, low-cost care, he said. But these systems are hard to emulate, Dr. Wachter said.

A small community hospital would be able to learn more about care integration from the way its own hospitalist group is working within its walls, he added. "In many ways [hospitalist groups] will turn out to be a model, a leading edge for doctor-hospital integration going forward," he predicted. ■

ICU Handoffs Hard to Define, Easy to Fumble

BY DAMIAN McNAMARA

MIAMI BEACH — Most critical care patients experience at least 20 "handoffs" during their average 4-day hospital stay—handoffs that are "major opportunities for miscommunication" that can lead to errors, Dr. Andrew Shorr said.

"These handoffs happen routinely, and we have little published evidence about them. …If this were going to be an evidence-based talk, I could sit down right now," he said at the annual congress of the Society of Critical Care Medicine.

He calculated the scope of the ICU problem as follows: two physician handoffs and three nursing handoffs per day, multiplied by four for the average length of stay, equals at least 20 handoffs. "And that is likely a conservative estimate," he said.

Physicians "don't know any systematic way to do this," said Dr. Shorr, associate section director of pulmonary critical care, Washington (D.C.) Hospital Center, and a member of the medicine faculty at Georgetown University.

The complexity of ICU care is one challenge: In a study, a checklist developed by surgeons worked well for handoffs in all hospital settings except critical care (J. Surg. Educ. 2008;65:476-85).

The noise level and degree of privacy also can play a role. "If this is in a busy cafeteria while someone is grabbing coffee and about to leave, [the handoff] is probably not going to go well," Dr. Shorr said.

Moreover, there is no standard definition of an effective handoff, he said. A handoff should involve interactive, up-to-date communication that employs repeat and readback techniques, according to the Joint Commission's National Patient Safety Goals. "I've never seen that in the ICU," he said.

In addition, about one-third of malpractice claim reviews involve communication errors, and 40% of those refer to patient handoffs, Dr. Shorr said. A prospective study is needed to determine the most effective system for handoffs in the critical care setting, he said. ■

Disclosures: *Dr. Shore had no relevant financial relationships.*