LEADERS: DR. JEFFREY J. GLASHEEN

Training the Next Generation of Hospitalists

When Dr. Jeffrey J. Glasheen finished his residency nearly a decade ago, he was embarrassed to discover that he wasn't prepared to face the realities of practicing as a hospitalist.

And when he asked around, it turned out that neither were many of the other newly trained hospitalists. Today, Dr. Glasheen is director of the hospitalist training program at the University of Colorado, Denver, and devotes much of his time to making sure that residents interested in hospital medicine get more than just the traditional categorical internal medicine training.

JEFFREY J. GLASHEEN, M.D.

In the University of Colorado's program, residents receive traditional internal medicine training, plus rotations where they get in-depth experience in consultative and perioperative medicine, comanaging orthopedic and neurosurgery patients, managing stroke patients, and inpatient geriatrics and palliative care. Residents also learn nonclinical skills such as quality improvement, patient safety, hospital leadership, and health care finance.

The goal of the program is to train "future leaders and stewards of resources" who can help build a more efficient, high-quality system within the hospital, said Dr. Glasheen, who also is the director of the hospital medicine program at the university.

"Our program is not necessarily for people who want to go out and be clinicians seeing 15 patients a day and go home," he said. "Our program is really for people who want to lead change in a hospital setting."

In 2004, Dr. Glasheen and his colleagues launched the hospitalist training program, which is the longest-running hospitalist training program in the country. There are only a few comprehensive training programs like it, he said, though several other programs have begun to offer rotations devoted to training hospitalists. Dr. Glasheen predicted that over time, more universities will begin offering separate hospitalist training programs to keep up with trends in medicine and demand from residents.

"We can say come to Colorado and we'll train you to be a good researcher, a good subspecialist, a good primary care doctor, or a good hospitalist, and you don't have to decide until you get here," Dr. Glasheen said. "I think that's a big advantage for our training program and our house staff."

The program at the University of Colorado has been successful, attracting students from around the country. But it wasn't an easy sell at first—for students or the administration. Many people assume that an internal medicine residency, where residents spend 60%-70% of their time working on the inpatient side, would be ideal training for becoming a hospitalist. But the reality, Dr. Glasheen said, is that a hospitalist's job is often very different from the job of a resident.

In 2003 Dr. Glasheen set out to prove his point. He analyzed billing data to find out what community hospitalists actually do. He found that about 30% of a hospitalist's clinical duties fall into the categories of neurology, orthopedics, general surgery, and consultative medicine—areas only briefly touched on in most categorical internal medicine training programs (Arch. Intern. Med. 2007;167:727-8).

But even after the need for additional training became clear, creating a separate training program for hospitalists was challenging, Dr. Glasheen said. The major obstacles have been finding the time to add new elements to the already packed curriculum, changing attitudes about what is needed to train a qualified hospitalist, and finding faculty who can teach areas such as quality improvement, systems of care, and health care financing when they never received this training themselves, he said.

Despite the challenges, hospitalist training is flourishing at the University of Colorado. In addition to the residency training program, Dr. Glasheen and his team have started a clinical fellowship for physicians who are out of residency but want to spend a year getting training specifically tailored to hospital medicine. Last year they launched a 1-year program to train nurse practitioners to be hospitalists. That program has already drawn significant interest, he said. ■

By Mary Ellen Schneider

Communications Blackout Poses Patient Safety Challenge

BY SUSAN BIRK

CHICAGO — In the fall of 2006, a vendor accidentally cut the wrong cable in the computer room at Children's Specialized Hospital, New Brunswick, N.J., leaving the large pediatric rehabilitation provider's eight facilities without computers or phones for 3 days.

Staff continued to care for patients with semimanual systems, and no adverse events occurred as a result of the power loss. But the sobering experience sparked a comprehensive overhaul of the organization's communications downtime procedures, using a Six Sigma risk reduction method known as FMEA (failure modes and effects analysis). Widely used in manufacturing, the Six Sigma system was first created by Motorola as a method for improving quality and efficiency. The FMEA component involves rating on a numerical scale the risks associated with components in a process, then prioritizing corrective actions based on risk levels.

A root cause analysis and a review of policies and procedures revealed serious shortcomings, including gaps between the administrative policy and the emergency operations plan, inconsistencies across some departments, no policies and procedures at all in other departments, and critical steps that were missing, including a formal process for communicating to staff that systems were down, said Lorraine Quatrone, medical administrator at Children's Specialized Hospital.

"The staff was completely out of the loop," she said at the Joint Commission national conference on quality and patient safety. "We thought we had a plan in place," but "we were operating in silos."

The hospital tightened computer room security, revised the administrative policy, and developed a flowchart showing who should notify whom after a communications failure. For example, the chief information officer was instructed to notify the chief executive officer and the chief safety officer.

Staff awareness 'seemed pretty low at the beginning, but as time went on and we did drills to reinforce our commitment to the process, we started to see the results edge up.'

Following these quick fixes, "we could have sat back and said we're prepared," Ms. Quatrone said. Instead, the hospital decided to "drill down and look behind doors" using FMEA methodology.

The hospital identified potential areas of vulnerability and prioritized areas for improvement. "Our analysis told us we were weak in communication of unplanned downtime and the implementation of procedures," Ms. Quatrone said. In other words, staff needed to be alerted about a communications failure, and they needed to know what to do to ensure patient safety after they were informed about the situation.

The hospital developed a template for downtime policies and procedures for every department. In addition to asking directors and managers what their departments needed in order to continue to function without computers and telephones, the hospital asked them to look at their departments as suppliers of information to the organization and to indicate how they could help other departments.

"We wanted to make this an organizationwide commitment to helping each other," Ms. Quatrone said. Facilities management, for example, is now responsible for immediately distributing two-way radios to patient areas, making hourly rounds to check for emergency issues, and monitoring the hospital's energy management system. All nursing units are required to immediately begin recording the administration of all medications on a written worksheet.

The hospital also addressed procedures that would govern how each department would continue to function after systems were working again, including how information from the interim paper process would get entered into the electronic system. Once the system has returned to operational status, for example, pharmacy staff are required to enter all new medication orders electronically.

Following the revision of policies and procedures, department directors and managers were asked to educate their staff and to decide with them which electronic forms would be needed in paper form and where information should be kept. Information about the emergency plan became an integral part of new employee orientations as well, she said.

To measure the initiative's success, the hospital conducted a series of simulated downtime drills and asked a sample of employees six questions about the emergency plan, including "How would you complete an event report if the system went down?" and "Can you show me your department's downtime policy?"

Awareness "seemed pretty low at the beginning, but as time went on and we did drills to reinforce our commitment to the process, we started to see the results edge up," Ms. Quatrone said.

The need for emergency plans will become even more crucial as more providers move toward electronic medical records and continue to automate other systems. "You can't fall short of recognizing the value and importance of having a backup within your organization," she said. ■

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