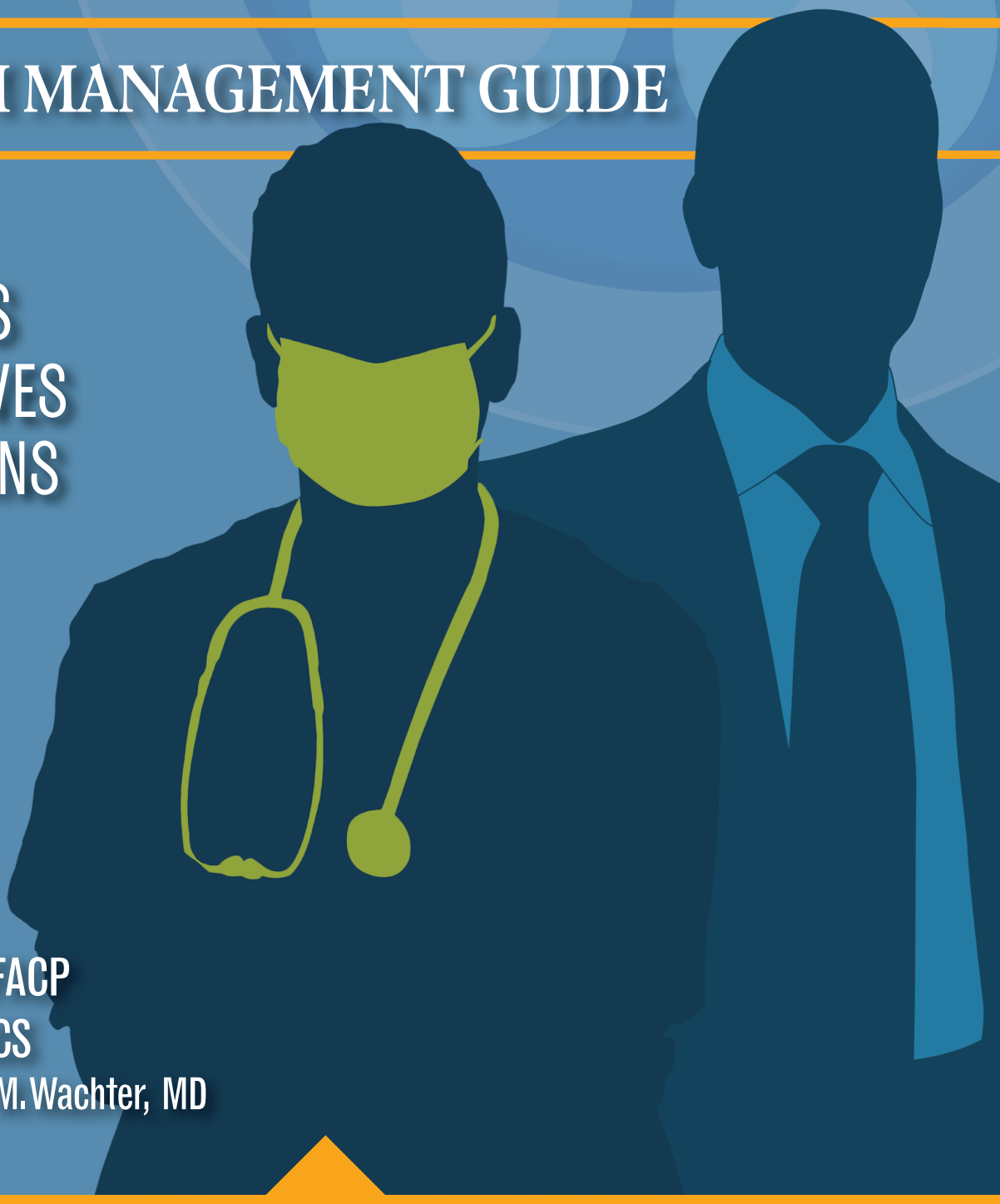
The SURGICAL HOSPITALIST

PROGRAM MANAGEMENT GUIDE

TOOLS AND STRATEGIES FOR EXECUTIVES AND PHYSICIANS



John Nelson, MD, FACP
John Maa, MD, FACS
Foreword by Robert M. Wachter, MD

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John Nelson, MD, FACP • John Maa, MD, FACS
Foreword by Robert M. Wachter, MD

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Maa received a patent for his invention of a safer central venous catheter and is certified by the American Board of Surgery. After his residency, he completed a fellowship in health policy at the UCSF Institute of Health Policy Studies, exploring mechanisms to improve the overall structure and processes of general surgical care nationally. During the fellowship, he also helped create the UCSF Surgical Hospitalist Program, which seeks to enhance the quality and timeliness of hospital-based emergency surgical care. His current research focuses on applying the surgical hospitalist model to improve hospital-based emergency care, specifically through new processes and strategies that address the challenges of emergency department overcrowding, boarding, and ambulance diversion. Over the past year, he assisted in the creation of a multidisciplinary course in public policy and advocacy for the professional schools of medicine, dentistry, pharmacy, and nursing at UCSF.

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Foreword

Robert M. Wachter, MD

The launching of a new specialty is exciting to watch. The idea often arises organically—a need is identified, a new technology materializes, a new patient population emerges. A few hardy physicians, often endowed with an organizational mind, a sense of plucky entrepreneurialism, and a sense of humor (and some Kevlar couldn't hurt) step in to fill the breach. Although some physicians decry this new specialty as heresy, others applaud the innovation. But most take a wait-and-see approach: "That's interesting, but show me the data."

Ultimately, all startups can survive and thrive only if they can answer (in the affirmative) a series of questions: Does this new field improve value—namely, quality divided by cost? Does the field successfully fill an obvious gap in clinical care? If so, the data and experience encourage others to try the new model, adapting it to their own local circumstances.

Meanwhile, the leaders of the new field, now convinced that their specialty will endure, begin mapping out the future. There are pragmatic questions: How should leaders organize these programs? Who should finance the field?

And there are more academic questions: How do we train specialists in this field? What types of new educational materials do the specialists need? What is the research agenda for the future?

Finally, there are social network questions: What are the best structures (conferences, e-mail list servs, etc.) to promote collegial exchange of dialogue? Is the field substantial enough to have its own society? Its own newsletter? Its own journal?

This is all near and dear to my heart, since it is precisely the path that John Nelson, Win Whitcomb, and I trod in the early years of the hospitalist field.[1] In 1996, I wrote an article, entitled "The Emerging Role of 'Hospitalists' in the American Health Care System," published in the *New England Journal of Medicine*, which coined the term "hospitalist" and introduced the concept to the healthcare community.[2] Soon after that article was published, Drs. Nelson and Whitcomb, two practicing hospitalists in

community settings, called me. Within months, we met and—armed with the hubris of youth—began to address all of these issues.

The rest, as they say, is history: The hospitalist field has become the fastest-growing specialty in the history of American medicine—from a few hundred practitioners in 1996 to more than 20,000 today. The field's specialty society, the Society of Hospital Medicine, is thriving, with nearly 9,000 current members,[3] and there are fellowship programs, research networks, textbooks, a journal, and even upcoming board certification for members of this new field. Why? Because the field met an important set of needs, demonstrated its value,[4] and ultimately won over even the naysayers.

When I first learned of the concept of surgical hospitalists from my UCSF colleague, Dr. John Maa, I had a sense of déjà vu. Up until that point, when I thought of a surgical hospitalist, I had in my mind's eye an internist-hospitalist helping comanage surgical patients, which is another rapidly emerging trend. But, as Dr. Maa described the rationale for inpatient-focused generalist surgeons, it made all the sense in the world, and I guessed that the surgical hospitalist model, like medical hospitalists a decade earlier, would become an enduring trend in American medicine.

In the first two years of the program at UCSF, our surgical hospitalists virtually worked and lived in the hospital for a week at a time, without a day off.[5] For that week, they were constantly available to the emergency department (ED) for consults. As a result, the average time at UCSF between an ED consult request and a surgeon's appearance in the ED is—I hope you're sitting down—16 minutes. Until I saw those data, I didn't know the elevators were that fast! In response to surveys, UCSF ED doctors and nurses were nearly euphoric with this unprecedented level of responsiveness.

Dr. Maa and his colleagues care for patients with a wide variety of clinical problems, ranging from cholecystitis to bowel obstruction. When the patient needs an operation that the surgical hospitalists feel is within their comfort zone (more than 90% of the time, in our experience to date), they perform the surgery themselves, shortening the time from diagnosis to incision for appendectomies by half. When the case is super-specialized or the patient has a long-standing relationship with another surgeon, the surgical hospitalists hand the patient off to the appropriate colleague. Although the surgical hospitalist service does receive medical center support dollars, the program also generates substantial new revenue through a marked increase in consultations, easing the need for financial subsidy.

The surgical hospitalist model extends our concept of a hospital-based generalist who offers full-time on-site availability, personally handles a wide variety of problems and coordinates the care of others, and focuses on improving both the care of individual patients *and* hospital systems. Like all healthcare innovations, the model has brought out the usual skeptics and naysayers. But with a huge shortage of surgeons—particularly general surgeons—available to cover hospital call[6] and a national crisis in ED overcrowding,[7] it is clear that the surgical hospitalist model addresses several critical problems.

Based on my experience with medical hospitalists, I predict that the surgical hospitalist model will grow and thrive. It will be critical to define the role better, in terms of schedules, training, reporting relationships, interactions with other surgeons, and more. Assuming that the model requires some institutional (usually medical center) support, hammering out the finances will also be crucial. If hospitals do chip in to support the program, key organizational questions arise: Should surgical hospitalists work for the hospital, or for medical groups, or for large regional or national companies? These questions are complex, and there is unlikely to be a single correct answer to any of them.

Because so many hospitals and medical groups are considering surgical hospitalist programs, the need for a resource like this book is compelling. The book offers information on the background, the business and clinical case for the innovation, and the nuts and bolts of implementation. This book represents the combined wisdom of many of the early physician and nonphysician leaders of the surgical hospitalist field, and it addresses the key questions. It will be a valued resource to those practicing in this field and those charged with organizing new programs. Although it is sure to find a large and enthusiastic audience among physicians and hospital administrators, my hope is that it also contributes to the ultimate goal of any new specialty—improving the care of patients.

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Preface

We see a book like this as an effort to tap into the thoughts and ideas of people who have demonstrated a commitment to developing and optimizing a future model of inpatient surgery practice. The fact that so many talented people have been willing to contribute to this effort is very gratifying, and we want to thank them for taking the time to provide their insight.

We wrote and edited this book in the spare time outside of our usual professional commitments. We owe a special thanks to our families for their understanding and support as we worked on this book, since they gave up some time with us so we could do this work.

A special thanks to Dr. Nancy Ascher, chair of the University of California, San Francisco (UCSF), Department of Surgery, and Dr. Hobart Harris, chief of the Division of General Surgery at UCSF, for their vision and support of the development of the UCSF Surgery Hospitalist Program.

We would also like to thank Drs. Guilherme Campos, Jonathan Carter, Laura Goetz, Jessica Gosnell, Electron Kebebew, Eric Nakakura, and Wen Shen for their invaluable contributions to the UCSF Surgery Hospitalist Program.

In loving memory of Laura Maa.

CHAPTER 1

Introduction

John Nelson, MD, FACP • John Maa, MD, FACS

The hospitalist model of medical practice has grown dramatically since the mid-1990s. The largest and most visible segment of this practice model is physicians trained in internal medicine, family medicine, or pediatrics, who provide care for hospitalized patients. These doctors are known either as hospitalists or pediatric hospitalists.

A less visible development is that the hospitalist model of practice has been adopted, at least to some extent, by many specialties in American medicine. We are aware of practicing GI hospitalists, orthopedic hospitalists, psychiatric hospitalists, obstetric hospitalists (often called "laborists"), and hospitalists in nearly every field, including general surgery. Healthcare administrators and providers will need to become familiar with what a surgical hospitalist practice might offer in their setting, as well as its limitations and costs.

During the past decade, a crisis in access to emergency surgical care has emerged, jeopardizing the ability of patients to receive optimal care in a timely and safe manner in our nation's emergency departments (ED). Both patient volume and complexity have increased, as increasing numbers of uninsured and underinsured patients have sought treatment in an ED. The traditional models of surgical call coverage have proven challenging, and a need has arisen to define new methods for surgeons to provide 24-hour coverage, seven days per week, particularly in the middle of the night and on weekends. A key intent of the acute care surgery and surgical hospitalist models is to propose solutions to the national crisis of access to emergency surgical care that promote efficiency, safety, and quality outcomes.

A central goal of this book is to share the experiences, insights, and valuable lessons learned from several of these emerging programs that will likely point to future directions as the field of emergency surgery continues to evolve. As of February 2009, we estimate that there are more than 30 surgical hospitalist programs across the country, and we anticipate that there will be approximately 300 within the next three years.

A key question is the required level of hospital financial support to a surgical hospitalist program. From our observations, this amount has ranged from about $400 to $3,500 daily, with most programs in the $1,000-per-day range. A particularly successful model has been the following: A multispecialty surgical group negotiates a daily stipend (perhaps $500) with the medical center leadership to provide timely and quality care consistent with the surgical hospitalist model. This additional funding allows the existing group to recruit a new surgeon (and often recent graduate) to join the multispecialty group and provide on-site dedicated coverage from 7 a.m. to 6 p.m. on weekdays. One of the more senior partners then rotates into the call scheme to cover the evening from 6 p.m. to 7 a.m. once his or her daily clinics and operating room (OR) schedules are completed. This method allows the junior surgeon an opportunity to build clinical skills, become familiar with the medical center, and have backup from senior surgeons on more challenging cases—while also providing a relatively balanced lifestyle.

This book is an effort to provide the collective experience of the 20 total contributors with this new and rapidly growing field. Each contributor has already had significant experience in this field, either as an administrator or as a clinician. In many cases, the contributors are the founding surgeons of their surgical hospitalist practice.

Organization of the Book

This book addresses the management of a surgical hospitalist practice. It is written for healthcare administrators and for surgeons and other caregivers involved in a surgical hospitalist practice. The first part of the book is a series of chapters that addresses specific operational and organizational issues, such as financial issues, staffing and scheduling, managing OR scheduling, etc. The second half of the book is a series of case studies. John Nelson is from a medical hospitalist background, and in the early evolution of that field, the case studies of individual practices in operation proved to be very useful and popular sources of information. We believe that the same will be true for surgical hospitalists.

Suggested Uses of This Book

We are confident that each chapter in this book will prove valuable to readers, and we have tried to sequence the chapters in a logical way. Yet we think that most readers will benefit by reading the chapters in any order that matches their interest. Some may choose to start with the case studies, and others may want to turn directly to a specific topic in the first section of the book.

One of the goals of writing such a book is to identify the contributors as potential ongoing sources of information. We encourage readers to contact the authors in this book if they have questions or would like to discuss an issue further. Each contributor's availability to respond to queries will vary, but all have significant interest in this emerging field and will be accumulating more information and experience that will allow them to refine their recommendations as the field evolves.

Using the CD

When you see the CD icon, you can find the figure (e.g., sample form, policy, chart, or further information) on the companion CD that comes with this book. You can then customize these documents for your own facility.

Terminology

We have used what we believe to be the most appropriate terminology throughout the book, but because this field is still evolving rapidly, we want to explain it here. We chose to use the term "surgical hospitalist" in the title and throughout the book because it can already be found in the existing medical literature and even when hearing it for the first time, most people in healthcare understand its intended meaning. We believe it is nearly universally understood to serve as a job description for general surgeons with a practice focused on the surgical care of hospitalized patients.

Other terms, such as "acute care surgeon" and "traumatologist," that have some overlapping meaning and sometimes are used interchangeably with "surgical hospitalist" have also appeared in the literature. But we believe there are meaningful differences between these terms. "Traumatologist" generally refers to a surgeon who is principally involved in the care of trauma patients, as might be the case in a Level I or Level II trauma center. (And confusingly, "traumatologist" is also used to describe a different group of caregivers, who provide mental healthcare to victims of physical or emotional trauma.) In Chapter 11, Drs. Maggio and Spain describe the acute care surgery model of practice.

When used without a modifier preceding it, the term "hospitalist" is widely accepted to refer to a doctor who provides nonsurgical medical care to hospitalized adults or children. To avoid confusion, we have used "medical hospitalist" to refer to these doctors to distinguish them from surgical hospitalists. We have chosen not to use "surgicalist" interchangeably with "surgical hospitalist," although the former occasionally appears elsewhere.

The overarching intent of this book is to stimulate a wider discussion of new models of emergency surgical care that are patient-centered, humane, responsive, and readily accessible to all. We welcome your insights, feedback, and suggestions of new solutions to the national challenges in the delivery of optimal and timely surgical care for our patients.

Voice

In editing these chapters, we've leaned towards preserving each contributor's own writing style, which means some chapters are written formally, and others more informally or colloquially. The surgical hospitalist field is still new, and the pools of people with experience come from diverse backgrounds and experiences and express their ideas in various ways. The careful reader may find conclusions and recommendations in one chapter that differ somewhat from those found elsewhere in the book. This reflects the variety of opinions and approaches in use currently, and we think there is value in being inclusive so that readers can have a broader understanding and form conclusions about the best approach for their own setting.

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