Core competencies show hospitalists’ potential for systemic improvements

Hospital administrators have a tendency to view hospitalists as floaters who fill in for other physicians, says Sylvia C.W. McKean, MD, FACP, medical director of the hospitalist service at Brigham and Women’s Hospital in Boston. With the publication of “The Core Competencies in Hospital Medicine,” the Society of Hospital Medicine (SHM, www.hospitalmedicine.org) hopes to dispel that view and emphasize hospitalists’ unique platform for facilitating organizationwide improvements.

“The role of the hospitalist is more than being on-site as a ‘super resident,’ processing patients for other physicians, and writing admission orders,” says McKean, one of five members of the Core Competencies Task Force appointed by the SHM (see sidebar on p. 4 for details about all five members). “Hospitalists have the potential to improve the system.”

“The Core Competencies in Hospital Medicine,” the result of a three-year effort, was published in a special supplement to the SHM’s inaugural January/February Journal of Hospital Medicine, the nation’s first medical journal devoted to research in the area of hospital medicine.

Market your hospitalist program to practitioners and patients

Astute facilities are recognizing that aggressively and proactively promoting their hospitalist program can mean a decided competitive advantage from a business development, marketing, and even recruitment perspective.

Less than a decade ago, healthcare leaders wondered just who these physicians were, questioned their staying power, and disputed their worth.

Today, there is no doubt that hospitalists are here to stay, providing value on many levels and driving hospitals that have embraced this model toward better, more patient-focused care.
Inpatient medicine. Designed as a guide that can be used for multiple purposes (e.g., writing curriculum for teaching hospitalists, developing a hospitalist program, or sharpening an individual physician’s skill set as a hospitalist), the document identifies 51 core competencies organized into three sections (see the sidebar on p. 3 for the complete list of competencies).

The competencies encompass guidelines for hospitalists in treating 19 clinical conditions (section one), performing eight procedures (section two), and fulfilling 24 roles related to the overall healthcare system (section three).

According to the task force members, the guide is intended for:
- directors of continuing medical education
- hospitalist fellowship directors
- residency program directors
- medical school internal medicine clerkship directors
- hospital administrators/leaders

**Competencies target organizationwide improvement**

A hospitalist program director of a new or fledgling program could use the guide to determine what a hospitalist program can or should add to an organization, says Michael Pistoria, DO, FACP, associate program director for the internal medicine residency program at the Lehigh Valley Hospital in Allentown, PA, and chair of the Core Competencies Task Force. The hospitalist can improve patient safety and efficiency of care and reduce practice variation, Pistoria says. “This is the value we help add to an institution.”

Whether each core competency could be applied to a system-based practice informed the choice of whether to include it in the final document, says McKean. For example, hyponatremia and other clinical conditions were not included on the list if the potential for system-based practice was missing, she says.

Some hospitalist program directors may think the list of conditions is incomplete, Pistoria says. However, he explains that the list is limited to conditions (e.g., community-acquired pneumonia) to which the task force thought a hospitalist would bring a significantly different approach than a family practitioner.

The hospitalist would be involved in efforts to comply with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and ensure that patients receive everything they need with regard to that condition or treatment. “We wanted to have something that defined what makes a hospitalist before someone put a label on us and pinned us into a corner where we may not necessarily have wanted to be,” Pistoria says.

**The hospitalist as teacher**

“This was not something we sat at the coffee table one day and just wrote,” says Alpesh N. Amin, MD, MBA, FACP, executive director of the hospitalist program and vice chair for clinical affairs and quality in the department of medicine at the University of California at Irvine Medical Center. “It was a significant undertaking,” he says of the peer-reviewed process that included hospitalists from every type of practice.

The task force developed a standardized format with each section organized into the following three or four parts (when applicable):
- Knowledge
- Skills
- Attitudes
- System-based practice

“Our hope is that [the competencies] will be a valuable tool for residency directors, clerkship directors, and fellowship directors,” says Amin.

According to McKean, administrators’ view of hospitalists simply as “floaters” is not the only misconception harbored about these professionals. They have also

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**Core competencies**

“We wanted to have something that defined what makes a hospitalist before someone put a label on us and pinned us into a corner where we may not necessarily have wanted to be.”

—Michael Pistoria, DO, FACP
been slow to recognize hospitalists as leaders, McKean says, because most newly minted hospitalists are right out of residency. “Many entrenched administrators don’t see the gray hairs and don’t see them as leaders.”

As a result, one core competency focuses on the hospitalist as teacher and leader. Hospitalists make great mentors, the task force members say, for two primary reasons: Their focus is hospital-based care, and they offer a consistent presence to physicians in training. The core competencies document will be especially valuable to physicians training in family medicine and internal medicine, say the task force members. McKean reiterates that hospitalists can teach a more systems-based approach to caring for patients and are often the natural choice to serve as leaders and teachers for the entire healthcare team on best practices, critical pathways, and JCAHO standards.

### A template rather than a rulebook

Amin notes that the core competencies guide is not meant to suggest that a good hospitalist

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**SHM’s core competencies**

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Five leaders in hospital medicine compose core competencies task force

The Society of Hospital Medicine (SHM, www.hospitalmedicine.org) announced in its January/February The Hospitalist that a team of five leaders in the field collaborated to produce the first core competencies for hospitalists.

The team, selected in 2003 to form the SHM’s Core Competencies Task Force, set out to develop guidelines that would define the system-based practice of hospital medicine and build a framework for adding future curricula, according to team member Alpesh Amin, MD, MBA, FACP, executive director and founder of the hospitalist program and vice chair for clinical affairs and quality in the department of medicine at the University of California at Irvine.

Task force member Sylvia C. W. McKean, MD, FACP, medical director of Brigham and Women’s Hospital/Faulkner Hospitalist Service in Boston, said in the article, “I identified what the newest members of our service right out of residency didn’t learn during their residency training and tried to make sure that we would have people come in and teach them about hospital medicine.”

She kept in mind which general areas were deficient and addressed them in developing the competencies.

Michael J. Pistoria, DO, FACP, medical director of the hospitalist service at Lehigh Valley Hospital in Allentown, PA, said in the article, “[W]e didn’t want to come up with a curriculum per se. We wanted to come up with a framework that someone could use to develop their own hospitalist program in their own institution.”

The remaining task force members are Tina Budnitz, MPH, senior advisor for planning and development at SHM, and Daniel D. Dressler, MD, MSc, director of hospital medicine at Emory University Hospital in Atlanta.

Editor’s note: For more information about this article, go to www.hospitalmedicine.org/Content/NavigationMenu/Publications/TheHospitalist/The_Hospitalist.htm.

Core competencies

must perform all of the duties identified in the document. Rather, he says, it provides guidance for clinical directors of hospitalist programs, hospitalists, and others on the medical staff about what the hospitalist should know if the practice includes the respective area of competence.

For example, although managing stroke patients is included as one of the competencies, the guide should not be interpreted to mean that all hospitalists should manage stroke patients. However, if your hospitalist practice does so, the skills and knowledge necessary should be identified in accordance with the core competencies. The task force members emphasize that the guide is a living document that will evolve as hospital medicine and healthcare evolves. In the future, new sections will be added and existing ones may be deleted.

Pistoria says the core competencies are a first edition and that the task force will revisit the guide based on feedback it receives from the field. “We plan to aggressively look at the [guide’s effect],” he says.

He says the idea for the guide originated at an early strategy session of the SHM, after it turned five years old. SHM wanted to define the role of the hospitalist before other people did.

Editor’s note: For more information about the SHM’s core competencies, go to www.hospitalmedicine.org/Content/NavigationMenu/Education/CoreCurriculum/Core_Curriculum.htm.
Hospitalist program

Marketing to PCPs

There was a time when community PCPs were reluctant to work with hospitalists for two main reasons.

First, PCPs questioned whether hospitalists could offer the same quality of care to their patients that they themselves could. After all, hospitalists didn’t know their patients, and referring long-standing patients to virtual strangers might lead to discontinuity of care. Those fears have long since been assuaged as PCPs have come to view hospitalists not as internists without offices who encroach on their territory, but as specialists, akin to cardiologists and oncologists.

Just as they would have no hesitation referring a patient to a disease-focused specialist if their expertise was needed, PCPs have come to realize that hospitalists are physicians who specialize in inpatient medicine and that today this specialization is necessary given that hospital patients are more medically complex and more acutely ill (often with multiple comorbidities) than in the past. Because of this, hospital medicine requires a decidedly different skill set than outpatient medicine—one that hospitalists are specifically trained to hone.

Second, many PCPs were apprehensive to refer their patients to hospitalists because they were afraid that they might not get their patient back after discharge. However, as more hospitalists dedicate 100% of their time to inpatient medicine (in the latest survey, more than 85% of hospitalists reported having no outpatient practice at all), that fear becomes increasingly unfounded. PCPs are beginning to view hospitalists not as competitors, but as partners.

Tout the advantages of a hospitalist partnership

Hospitals are wise to leverage this migration in thinking and market the existence of a hospitalist program to community physicians as a way to attract them to practice at their facility. Hospitals should emphasize that the hospitalist program exists to provide medical staff with the following advantages:

- **Hospitalists help PCPs refine their outpatient skills.** Thanks to hospitalists, PCPs now have the ability to focus all of their attention on their office practice and, in doing so, can better refine needed outpatient skills. This is particularly important because advances in medical technology have made it possible for physicians to deliver increasingly sophisticated care in the outpatient office.

- **Hospitalists eliminate the need for time-consuming hospital visits** From a pragmatic standpoint, it is no longer prudent for PCPs to run to their local hospital once or twice daily to see a diminishing number of patients. Today, the average PCP has one or two hospitalized patients per week versus 10–12 patients 20 years ago. What’s more, the typical PCP is unlikely to see any one condition that warrants a patient’s hospitalization more than three times per year, according to a study by the Healthcare Advisory Board in Washington, DC. Because hospitalists spend all of their time focused on acute conditions, they are better able to understand and treat them.

- **Hospitalists help PCPs avoid the dreaded emergency department (ED) on-call.** Hospitalists can relieve PCPs of weekend or evening call shifts in the ED and can also greatly minimize or eliminate the number of unassigned patients a PCP needs to see. Hospitalists can provide 24/7 and code-blue coverage, manage patients on weekends, and offer coverage when a physician is on vacation. This kind of support—which PCPs can leverage as fully or selectively as they wish—improves the PCP’s quality of life and work-life balance.

Marketing to nurses

Hospitals nationwide are struggling with severe nursing shortages. Given America’s aging population, it is estimated that 1.7 million nurses will be needed...
Hospitalist program

by 2020, according to the U.S. Department of Health and Human Services (www.hhs.gov). However, at the current rate the supply of nurses will fall short by 65%. In states such as California, state-mandated staff-patient nursing ratios make the need for nurses even more dire.

As a result, competition for nurses is going to become even more aggressive in the years ahead, pushing healthcare facilities to allocate more resources to recruit and retain their nursing staffs.

For several years, hospitals have been upping the ante with larger sign-on bonuses, relocation expenses, and perks such as health club memberships, babysitting services, and resort vacations in the hopes of attracting more nurses.

But with nursing student enrollment declining in reverse proportion to the increasing need, it is not simply a matter of who can recruit the most nurses from the diminishing pipeline. It is also a matter of getting them to stick around.

Hospitals that have hospitalist programs find that they have leverage in recruiting and retaining nurses because hospitalists make nurses’ jobs more efficient, relieve some of the pressure and responsibility, and develop an esprit de corps that most nurses find appealing. As a result, savvy hospital marketing directors are working with their human resource departments to integrate the hospitalist story into their recruitment and retention messages. Among the points they stress are that hospitalists

- **improve physician/nurse interaction and communication.** Simply put, hospitalists are bringing back the team approach to patient care. Because hospitalists are on-site at the hospital tending to patients virtually 24/7, they interact face-to-face with nurses multiple times daily. There is greater communication between the nurse and physician, creating a collegial relationship that ultimately benefits the patient. It follows that the more interaction fostered between physicians and nurses, the more informed the hospitalist will be about issues affecting nurses and the greater the opportunity for collaboration and the leveraging of ideas to the medical staff and administration will be.

- **champion causes that affect nurses’ jobs.** Hospitalists play a key role in successfully improving overall hospital efficiencies, which in turn provides benefits to nurses. Because hospitalists are on-site, they see firsthand the inefficiencies, stresses, and problems within the system. They have become champions of improved systems and advocates for change of frustrating and outdated systems. This also improves a nurse’s working conditions.

- **aid nurses’ on-the-job learning.** Hospitalists provide tremendous support to nurses when there is an emergency or during late-night shifts when hospitals often have their newest and least experienced nursing staff on duty.

- **improve the nurse-patient relationship.** A patient who has questions about his or her treatment and waits hours to meet with a physician can become frustrated, demanding, or uncooperative with nurses. This usurps nurses’ time and creates additional stress. However, due to their on-site availability, hospitalists often are able to speak with their patients within minutes. As a result, patients have more confidence in their care and are less demanding of the nursing staff.

Marketing to the community

For patients, having a physician they don’t know walk into their hospital room can be disconcerting. If not managed properly, there exists a potential dichotomy between patient perception and acknowledged reality. By working with their local media, capitalizing on hospital-produced publications, speaking in community forums, and taking advantage of other marketing vehicles at their disposal, hospitals are beginning to tell their local constituencies a compelling hospitalist story. They are pointing out to patients and their families the following advantages of going to a hospital that has a hospitalist program in place:

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Hospitalists enable around-the-clock access to a physician. Because hospitalists practice on-site in the hospital, they are there whenever the patient or family member has a question regarding care. Patients no longer have to wait until their physician makes his or her rounds (often at inconvenient hours for the family) to obtain answers. In addition, no longer must the patient or family wonder who is in charge. The hospitalist is not only in charge, but is accountable.

Hospitalists expedite tests results and overall care. By being located in the hospital, hospitalists know how to expedite and improve care within that environment. If test results from pathology or radiology come back, the hospitalist is there to act on them immediately and ensure that the patient receives what he or she needs right away. In addition, they are familiar with all of the key individuals in the hospital (e.g., medical and surgery consultants, discharge planners, clergy, etc.). Hospitalists can also better facilitate connections with postacute providers (e.g., home health, skilled nursing, and specialized rehabilitation).

Hospitalists become a familiar face among many providers. Hospitalists provide better continuity of care for the patient by improving the communication in shift hand-offs between day and evening nursing shifts and coordinating sometimes as many as 50–100 providers who are involved in the care of a given patient.

Hospitalists intimately know “hospital” medicine. Medicine is a field in which best practices emerge from increased experience. Hospitalists bring to the patient a unique expertise in the care of common acute disorders. Because of their unusually deep understanding of inpatient care, hospitalists are able to recognize and diagnose unusual disorders, anticipate problems, and rapidly respond to crises or changes in a patient’s condition.

Hospitalists speed patient discharge and improve patient satisfaction. Research has shown that hospitalists help reduce patient lengths of stay and treatment costs and improve the overall efficiency of care for hospitalized patients. Hospitalists also have been shown in recent studies to reduce mortality rates, improve clinical outcomes, reduce readmission rates, and positively affect the quality of medical care and patient satisfaction.

Marketing value
Hospitals enjoy having hospitalists on staff for a growing number of reasons. In addition to the benefits they provide at the patient bedside, hospitalists are proving to be the catalysts for continuous quality improvement within a facility—from advocating systemic changes to providing firsthand input into medical staff policies to engineering changes in standard hospital procedures.

What’s more, hospital CEOs who have recently begun to worry about the future of their medical staffs realize that in hospitalists, they have dedicated partners.

Because hospitalists are at the hospital all the time, they share CEOs’ interest in ensuring that the hospital runs optimally, waste is minimized, and maximum coordination takes place at all levels.

Medical staff committees also benefit from the presence of hospitalists. Committees focused on utilization review, patient safety, pharmacy and therapeutics, ethics, case management, geriatric medicine, medical records, credentials, discharge planning, quality, and infection control could benefit from hospitalists’ vocal participation. In fact, there are no committees at the hospital to which a hospitalist couldn’t offer a perspective and commitment that would add value to the facilities’ ongoing operation.

Hospitalists’ clinical value is clearly demonstrated, their operational value is coming to the forefront, and now hospitals are realizing that hospitalists can provide a competitive marketing advantage on multiple levels. As the benefits of their presence become clearer, hospitals would be well-advised to trumpet the contributions hospitalists make to distinguish their facility in a compelling and powerful way.
In an epidemic or disaster, hospitals would need to reorganize for mass emergency critical care

Epidemiologists and health officials worldwide are carefully tracking flu cases to head off a potential deadly avian flu pandemic. If a flu pandemic or disaster of any type does occur, the nation’s hospitals must be prepared to modify the critical-care services they routinely provide in favor of offering mass critical care to the greatest possible number of patients, says Lewis Rubinson, MD, PhD, county health officer for the Deschutes County Health Department in Bend, OR, and an intensivist at Bend Memorial Clinic.

As a result, hospitalists—through their 24/7 presence in hospitals and intimate knowledge about patient flow issues—could play a significant role in treating mass volumes of patients. At many facilities, hospitalists have not been included in epidemic or disaster preparedness planning for two primary reasons, according to Rubinson: Their specialty is new, and inpatient populations are rarely the focus of disaster planning. Historically, physicians and medical staff leaders from emergency medicine, mental health, radiology, and surgery departments have been the most active in planning for such events, he says. However, “hospitalists need to bring their perspective [to disaster planning]—a perspective the rest of the hospital doesn’t have,” Rubinson says.

Rubinson is one of 33 experts who compose the Working Group on Emergency Mass Critical Care, which was organized by the Center for Biosecurity at the University of Pittsburgh Medical Center and the Society of Critical Care Medicine (SCCM, www.sccm.org) to give recommendations to hospital and clinical leaders about critical-care services during bioterrorist attacks, epidemics, and other disasters. The group published its recommendations in the October 2005 issue of the SCCM’s journal Critical Care Medicine. “Critical-care surge capacity is the big white elephant no one was talking about,” Rubinson says.

Mark Ackermann, chief administrative officer at St. Vincent’s Catholic Medical Center in New York City and another member of the Working Group, agrees that the topic is one that has not been given adequate attention. He says that Americans must understand that in a pandemic—or in any disaster that requires mass critical care—patients will be prioritized based on age or severity of injury. “If they are beyond help, we will not be able to expend precious resources on treating these patients, other than making them comfortable.”

For example, he adds that Israelis, who are accustomed to living under the constant threat of terror and the resulting mass casualties, understand this, but most Americans don’t.

Critical care is key

In an avian flu epidemic, there may not be a disease-specific treatment, and it is not clear whether antivirals will work, Rubinson says. “Supportive care will be key,” he adds. To meet the demand for mass critical care, hospitals would need to change their focus from providing almost unlimited care and interventions to a few patients to managing resources enabling the provision of one set of key critical-care services to as many patients as possible, he says. Specifically, hospitals would need to make changes in

- the spectrum of critical-care interventions offered
- existing triage systems
- medical equipment/supplies available
- staffing considerations
- clinical trials

Ackermann says the Working Group’s mass critical-care recommendations are being incorporated into his hospital’s disaster preparedness plans. Notably, St. Vincent’s received one of the highest numbers of patients (844) injured during the September 11, 2001, terrorist attacks on the World Trade Center.

Ackermann says the city’s experience with a mass casualty event has caused it to take disaster preparedness very seriously. And although New York
Emergency critical care

hospitals take an “all-hazards approach,” he says they are also actively planning and preparing for a pandemic.

Spectrum of critical-care interventions
The Working Group states in the article that during a mass casualty event, hospitals should give priority to interventions that
- have been shown or are deemed to improve survival
- do not require expensive equipment
- do not consume extensive staff or hospital resources

Based on these criteria, the Working Group states that hospitals should plan to deliver the following during emergency mass critical care:
- Basic modes of mechanical ventilation
- Hemodynamic support
- Antibiotic or other disease-specific therapy
- Prophylactic interventions that reduce serious adverse consequences of critical illness, such as maintaining the head of a ventilated patient at 45 degrees and using thromboembolism prophylaxis

Positive pressure ventilation would be a priority in an epidemic in which patients would be expected to have acute respiratory distress syndrome. The ventilators need not be state-of-the-art, but it should be rapidly available and portable, provide adequate gas exchange for a range of clinical conditions, and allow for efficient use of the staff, the Working Group states in its recommendations.

The Working Group addressed four major areas of consideration:

1. Triage:
“Currently, when most people talk about triage, they are applying a trauma model for triage,” Rubinson says. In a situation of mass critical care, people should be triaged based on their likelihood of survival with critical care, according to the Working Group. Providers could establish broad categories of survival such as low, medium, or high likelihood of death.

In a pandemic, providers may have to use real-time information about the prognoses of patients with an undetermined flu virus. If early predictors of survival are identified, providers could use these predictors to guide triage. Providers could also give all patients a trial of essential critical care and withdraw care from those who do not clinically improve after a set period of time.

Rubinson says it is important for hospitals to address the issue of emergency mass critical care triage pre-event and obtain public input. An example of a question to address is, “If there is not enough capacity, how do you prioritize in a way that is fair so that you are not making social judgments?”

Developing criteria for mass emergency critical care also has many ethical and legal ramifications, and legislative action may be needed in advance of such a crisis to protect hospitals and healthcare workers from liability, the Working Group states. “Executive orders are signed and prepared and sitting in envelopes in the [New York State] governor’s office to help resolve liability and privacy issues,” Ackerman says.

2. Medical equipment:
The Centers for Disease Control and Prevention, which operates the Strategic National Stockpile (a supply of medicine/medical supplies to protect the American public if there is terrorist attack, flu outbreak, or other disaster severe enough to cause local supplies to run out), has thousands of portable ventilators that can be deployed, Rubinson says.

However, there could be delays in receiving the ventilators and supplies could be limited if several hospitals compete for them.

Rubinson says few hospitals can afford to purchase enough ventilators to significantly increase their intensive care unit capacity, so hospitals should consider joining with other hospitals to create local, regional, or state stockpiles. He notes that it is a good idea to have an “overarching, larger jurisdiction purchase a stockpile.” He adds that “a
cache held by a ‘higher broker’ [other than one at an individual facility] could make honest decisions about where they were most needed.” According to Ackermann, some ventilators are currently distributed from local stockpiles for hospitals to use now and then calibrated and maintained. He says his hospital’s “standing orders” with pharmaceutical and equipment suppliers for ventilators could be activated with a key stroke or a phone call.

Ensuring that a facility has adequate medical supplies for an epidemic or disaster is another important consideration. For example, during the SARS outbreak in early April 2003 in Toronto, one Ontario hospital used 18,000 masks per day, the Working Group notes.

3. Staffing:
In a pandemic, there likely would not be enough intensivists and critical-care nurses to care for all patients requiring critical-care services. As a result, the Working Group recommends the use of a two-tiered staffing model for mass critical care by physicians. Intensivists would be responsible for managing acute emergencies and guiding nonintensivists, who would be responsible for general medical management of patients. The Working Group estimates in the article that one nonintensivist could manage approximately six critically ill patients and that an intensivist could coordinate the efforts of up to four nonintensivists.

Two-tiered staffing also could be used for nurses, with critical-care nurses guiding noncritical-care nurses. In addition, hospitals providing emergency mass critical care likely would require additional respiratory therapists and pharmacists.

Hospitals should develop preprinted clinician order forms to improve standardization of medical care, the Working Group writes. Additional order sets specific to the disease could be developed during the crisis. “One of the biggest challenges is infection control [IC],” says Rubinson. He stresses that it is important to ensure that staff have a good understanding of how to apply IC measures in place. “[Staff] have to learn how to use personal protective equipment and really understand how to use gloves, gown, and mask without self-contaminating.” Ackermann says that assuring staff that every precaution will be taken to protect them and their family members is important so they will be comfortable reporting for duty.

Hospitals should also consider, that using volunteer help in a disaster or epidemic may not be an option, Ackermann says. On September 11, 2001, thousands of people surrounded St. Vincent’s hospital to reach out and help, but during a pandemic, “no one will want to get near the place,” he says.

4. Clinical trials:
When many lives are at stake, physicians and other providers will be eager for information about therapies or techniques that are observed to improve survival during an epidemic. “Hospitals should have information technology capabilities for analyzing clinical data for patients receiving emergency mass critical care and for quickly sharing new observations with a broader clinical community,” writes the Working Group in the Critical Care Medicine article.

Even small modifications could have a tremendous effect, Rubinson says, citing a research study about acute respiratory distress syndrome that reported significantly improved outcomes with just “one little tweak of the ventilator.” Ideally, modifications in techniques and therapies would be tested before the information was shared, but that is not always possible for ethical and other reasons, Rubinson says.

Although they have not yet played a great role in disaster preparedness, hospitalists should consider how they would test therapies that appear to hold promise during an epidemic, Rubinson says.
Hospitals ill-prepared to deal with coming changes

The hospital industry is due for a host of changes in the coming years, and most of the nation’s hospitals are not adequately prepared to deal with them, according to an article posted on the Web site of The Heartland Institute (www.heartland.org), an independent, Chicago-based research firm.

Greg Scandlen, founder of Consumers for Health Care Choices (www.healthcarechoices.org), a national nonprofit organization based in Hagerstown, MD, described the following changes that will directly affect hospitals in the coming years:

- The trend toward consumer-driven healthcare
- An increase in the number of uninsured people
- A spike in the number of healthcare lawsuits
- Ongoing patient safety concerns
- Medicare payment reductions

Scandlen focused on two key issues: what he calls “the overcharging of self-pay patients,” citing a 400%–500% markup in the price of services from the figure that a preferred provider organization patient pays, and an explosion in the number of Americans covered by health savings accounts (HSA) and health reimbursement account (HRA) programs.

“This over-charging discourages many self-pay patients from even trying to pay the bill,” Scandlen wrote. “They will examine their billing statements carefully, much like the HAS/HRA patients will, and they will complain when charges seem excessive.”

In addition, Scandlen outlined a major expense for hospitals in the form of lawsuits. Roughly 400 nonprofit hospitals in at least 25 states have been charged with violating their implied contract with the state to provide care to the indigent in exchange for their tax exemption, wrote Scandlen.

Continued concern over the Institute of Medicine’s 1999 study “To Err Is Human”—which estimated that 98,000 people die from medical errors every year in the United States—and increasing federal antitrust scrutiny, will put added pressure on hospitals, wrote Scandlen.

Scandlen also speculates that Medicare payment reductions to hospitals, the end of Specialty Hospitals Moratorium, and growing competition from offshore medical tourism are all likely to negatively affect hospitals in the coming years.

“Hospital administrators must do a sober assessment of the stakes here,” wrote Scandlen. “The perception that hard-working consumers are being overcharged by dangerous and poorly run facilities that have conspired to retain a monopoly position in the healthcare system has set the stage for a devastating attack on the hospital system.”
The JCAHO warns of drug errors during patient transfer and discharge

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a Sentinel Event Alert on January 25 to accredited hospitals, advising them to closely monitor the medication reconciliation process, which is the review of a patient’s medication to avoid errors or adverse events.

Specifically, hospitals should intensify efforts to highlight medications on patients’ medical charts to avoid errors that often occur during transfer of a patient between units or during discharge. The alert identified the following potential medication errors that can occur as a result of inadequate communication or poor record-keeping:

- Giving a patient double the prescribed dose
- Administering the wrong drug
- Giving a patient incompatible drugs

According to the JCAHO, 63% of reported medication errors resulting in death or serious injury were due to breakdowns in communication among healthcare practitioners.

The Joint Commission also states in the alert that more than 2,000 reports of medication reconciliation errors were received last year by U.S. Pharmacopeia, an independent organization that has implemented a voluntary medication error reporting program for health-care practitioners.

To access the alert, go to www.jcabo.org/about+us/news+letters/sentinel+event+alert/sea_35.htm.