SHM survey: Workload, heavy demands top concerns for hospitalist leaders

When hospital medicine leaders were asked in a 2005–2006 Society of Hospital Medicine (SHM) survey to identify their primary concerns, the dominant theme throughout the list (see sidebar on p. 3) was clear: Workload, demands, and job sustainability are top of mind.

Specifically,
- 42% cited work hours and work/life balance as the most important concern
- 29% identified daily workload as their biggest care
- 23% pointed to hospital expectations/demands as their primary worry

Another related concern—recruitment—broke into the top three with 35% of those surveyed citing it as a major worry.

Although the SHM survey results bring answers to the question of what keeps hospitalist leaders up at night, they also create more questions. What is the major reason for this pervasive sense of feeling overburdened in the field? Is it due to the number of patients hospitalists see, their expanding scope of practice (i.e., “mission creep”), hospitals’ expectations that they perform nonclinical activities, or a combination of these factors?

Newborn services by pediatric hospitalists a plus in marketing

The provision of newborn services by pediatric hospitalists not only can provide steady work and revenue for pediatric hospital medicine programs, which often struggle with low volume and fluctuations in demand for services, but it can also make your hospital more attractive to parents. “The idea of having a pediatrician to attend to the unexpected needs of the newborn is a marketing plus,” says Carlson. If a problem develops with a child in a delivery (e.g., if the infant is lethargic or does not cry, or there are signs of deceleration), a pediatric hospitalist is on the scene to evaluate the child immediately.

When mothers are shopping around for where to deliver, this is clearly a plus in making that informed decision,” Carlson says.

A pediatric hospitalist program
Of course, circumstances vary with individual hospitalists and hospital medicine programs, and the survey results do not make it possible to specify the causes of this stress. However, leaders in the field have their own interpretations of the results—what they mean and what is to be done about them. The 2005–2006 SHM survey results, based on the responses of 396 hospital medicine groups representing 2,550 hospitalists, account for 17%–20% of the nation’s hospitalists.

**Work environment**

Mary Jo Gorman, MD, MBA, member of the Physician Advisory Board of North Hollywood, CA–based IPC—The Hospitalist Company and the current SHM president, says it is human nature to “want to work less and make more money,” but agrees that the responses clearly indicate that work stress is a significant issue in the field of hospital medicine.

Beyond their regular clinical duties, hospitalists are often expected to help in the emergency department (ED), deal with patients’ family issues, and participate in risk management initiatives, she adds.

An often-overlooked reason that physicians feel overwhelmed on the job, according to Gorman, is the environment. The SHM survey sends a message that hospital work environments must improve, Gorman says. “The work environment is critical to how happy a person is on the job.” Many factors contribute to the quality of the environment and not all of them have to do with workload and compensation. For example, Gorman cites electronic medical records and easy access to lab reports as important ways to improve hospitalists’ work environment.

The good news, Gorman notes, is that although burnout has been a concern in hospital medicine, there are also indications from the survey that hospitalists are staying in the field.

The survey found that the ages of hospitalists have increased slightly: 51% of hospitalists are aged 35–50, compared with 48% in that age group in the previous survey (2003–2004). About 40% are under 35, a slight drop from the 43% who were under 35 in the previous survey.

**Scheduling**

John Nelson, MD, director of hospital practice for Overlake Hospital in Bellevue, WA, says that although many hospital medicine groups “have too much work by anyone’s assessment,” some hospitalists may be feeling overburdened because of scheduling. “They’ve chosen to do a reasonable amount of work in an unreasonably short amount of time,” he explains.

Many hospitalists want to work regular daytime hour shifts, but day shifts do not necessarily match the work distribution, says Nelson. If four hospitalists are scheduled to work the 7 a.m. to 7 p.m. shift, and one is scheduled to work the 7 p.m. to 7 a.m. shift, there may be a situation in which a few hospitalists are not very busy at 3 p.m., yet at 7 p.m., there are six patients waiting for the lone hospitalist at the shift change, he says. “You would feel stressed if you had six patients waiting for you,” he says.

Working a schedule of seven days on and seven days off holds the appeal of building a lot of personal time into one’s work life, but hospitalists on this schedule are likely to feel overworked, Nelson says. “Every time they show up for work, there will be a ton to do, but they’ve done it to themselves.”

Nelson believes in being flexible about work hours instead of strictly adhering to a schedule. In his own work life, he tries to adjust his hours to the flow of patients—leaving work early when it’s slow and staying later when it’s busy. He acknowledges that although many people like predictable work hours, such schedules impede efficient work in hospital medicine, where the workflow is often unpredictable.
**Mission creep**
The more likely reason behind the work stress reported in the SHM results is the volume of patients hospitalists see, Nelson says.

However, he acknowledges that mission creep—or an expanding scope of practice—may also be part of that stress. He says neurosurgeons ask him whether hospitalists can take care of intracranial bleeds, orthopedic surgeons ask whether they can admit hip fracture patients, and the CEO asks whether hospitalists can do the history on psych admissions. “I get tired of saying, ‘I don’t think we can do that yet,’” Nelson admits.

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**Frequency of concerns identified by HMG leaders—Top 10 list**

In the 2005–2006 Society of Hospital Medicine (SHM) survey, leaders of hospital medicine groups were asked to rate their most important concerns from a list of 28 work issues. The following are the 10 most frequently cited concerns:

1. Work hours/work life balance—42%
2. Recruitment—35%
3. Daily workload—29%
4. Expectations/demands from hospital—23%
5. Reimbursement/collections—17%
6. Professional respect/job satisfaction—17%
7. Career sustainability—15%
8. Retention—15%
9. Quality of care/quality indicators—13%
10. Specialist availability for consultation—11%

**Mean percent of encounters by category**

- Admissions, follow-ups, discharges: 77.3%
- Consultations: 8%
- Observation days: 6.2%
- Critical care: 4%
- Procedures: 1.7%
- Other encounters: 100%

**Nonclinical activities**

- Committee participation: 92%, New: 3%
- Quality improvement: 86%, New: 2%
- Practice guidelines: 72%, New: 6%
- Pharm/therapeutics committee: 64%, New: 3%
- Utilization review: 59%, New: 3%
- CPOE/information systems: 54%, New: 19%
- Teaching—house staff: 51%, New: 10%
- Teaching—non-MDs: 36%, New: 7%
- Recruit/retain MDs: 31%, New: 6%
- Community service: 28%, New: 5%
- Disaster response planning: 25%, New: 9%
- Research: 21%, New: 11%

**Percent of time spent on nonclinical activities**

- Mean: 11.6%
- Median: 10%

Besides clinical mission creep, there is also the non-clinical variety. The recent SHM survey identified 12 nonclinical activities in which hospitalists are engaged. (See sidebar on p. 3.)

**Robert Wachter, MD**, chief of the medical service at the University of California, San Francisco Medical Center, says that when the hospitalist movement began more than a decade ago, the Institute of Medicine had not yet released its landmark report on patient safety, and there was not yet the intense focus on quality measures that there is today.

“At the time, there was much less ‘systems stuff’ to be part of,” he says.

But as pressures mounted to improve patient safety and quality of care, Wachter says he and the leaders of the budding hospitalist movement could already see the natural marriage between these evolving priorities in healthcare and the largely young physicians entering the field of hospital medicine who were not tied to the old ways, were computer savvy, and were comfortable working with administrators and nurse practitioners. This marriage would also serve to address some of the economic challenges that hospital medicine programs face (i.e., many are not self-supporting under fee-only plans and therefore require the hospital’s support).

Hospitalists were developing a reputation for decreasing patients’ length of stay, improving throughput, and cutting costs, Wachter says. But he and other hospital medicine leaders were wary of this “cost-saving” image, he says. However, the evolving focus on patient safety and quality improvement presented an opportunity for hospitalists to develop a new brand based on “improving value and efficiency and quality systems,” Wachter says.

**Importance of leadership**

Although Nelson readily says no to responsibilities that the service cannot reasonably meet, he says a hospital medicine program can’t think, “I’m not an orthopedist; we’re not going there. Scope of practice is dynamic, not static,” which he says is also true for any modern-day physician.

Nelson recommends keeping a list of all of the requests the hospital medicine service receives from administrators and other physicians and every year stepping forward to meet some of the top requests.

If hospitalists fail to meet new requests, he warns that they run the risk of having new duties imposed upon them when the demand builds.

Hospital medicine leaders play a critical role in skillfully fielding requests, says Wachter, who compares a hospitalist to a Swiss army knife. “We are the solution for all sorts of problems no one’s thought of.”

A good leader will be able to prioritize and manage requests and know when to say no, Wachter says. In the early days of hospital medicine, when the hospitalist staff likely consisted of six physicians right out of residencies, the “leader” was the one who didn’t mind going to meetings, he says.

Now leadership is seen as a critical skill for hospitalists, and leadership development is a critical part of a hospitalist’s training. Wachter says he spends a lot of his time setting limits and boundaries for the hospital medicine program and being a “traffic cop.”

“I will say no [to a request] if it goes beyond what we can provide without compromising other fundamental tasks,” he says. He also denies requests to perform impossible or unsafe tasks (e.g., providing complex care to neurosurgical patients) or requests that ask for “a level of commitment that goes well beyond the level of support.”

The house officer: A practitioner on the verge of extinction?

Q: Have hospitalists replaced the need for house officers?

A: This is a complex question, and depends largely on how your organization defines “house officer.” In some institutions, house officers are called upon to provide specific tasks such as starting difficult-to-access IVs, obtaining arterial blood gases, responding to patients whose clinical status is rapidly deteriorating, etc. House officers’ main responsibility is providing crisis intervention and being available at times that are inconvenient for the attending physician of record (e.g., late night, early morning, weekends, etc.). At many hospitals, interns and medical residents provide these services.

Hospitalists, on the other hand, are typically looked upon to lead their institutions. They are expected to have a firm grasp of the healthcare delivery system and work intimately with all stakeholders.

Their skill sets and responsibilities may include:

- vertical integration of patient care
- management and coordination of the bulk of inpatient care at the institution
- maintaining high-quality medical care and standards
- maintaining continuity of care
- possessing excellent communication skills
- developing and maintaining solid relationships with the referral base and other practitioners
- possessing superb customer service skills
- communicating with patients and their families
- providing added-value services to the institution

It is in the added-value category that hospitalists’ duties may approximate house officer responsibilities. To what extent depends on the philosophy of the hospital, the mission and objectives of the hospitalist program, and the financial resources available. Some institutions are hesitant to overextend their hospitalists for fear of burnout. Many hospitalist groups view themselves as a practice and see the house officer duties as demeaning “scut” work, whereas other programs enthusiastically provide any and all services necessary to make themselves invaluable to the institution and medical staff.

Editor’s note: Kenneth G. Simone, DO, founder and president of Hospitalist and Practice Solutions, based in Brewer, ME, answered this month’s ‘Ask the expert’ question. Contact him at ksimone@sunburypc.com.

Pediatric hospitalists

can also provide newborn services to unassigned patients and link families with a primary care provider in the community, Carlson says.

The Washington University School of Medicine has 26 pediatric hospitalists staffing three hospitals: St. Louis Children’s Hospital, the 489-bed Missouri Baptist Medical Center, and Barnes-Jewish Hospital, a large urban 962-bed hospital that ranked sixth in the most recent U.S. News & World Report’s annual listing of top hospitals. Pediatric hospitalists from the School of Medicine will soon provide services at a fourth 72-bed hospital, Progress West, now under construction in an adjoining county.

“The term hospitalist implies inpatient medicine,” Carlson says. “What we really are, are pediatric generalists working in hospitals.”

Attending deliveries

Washington University’s pediatric hospitalists currently provide newborn services at Barnes-Jewish Hospital and Missouri Baptist Medical Center. The hospitalists do not attend normal deliveries, Carlson says. But they do attend caesarean and complicated deliveries at Missouri Baptist Medical Center, which has about 4,000 deliveries per year. “As soon as the baby is born, it is handed to us in delivery for evaluation or resuscitation,” he says.
Pediatric hospitalists

At Barnes-Jewish Hospital, physicians often work with indigent patients who have psychosocial issues, and the pediatric hospitalists play an especially critical role, Carlson says. The hospital has about 5,000 deliveries per year, and many newborns are unassigned. Working with these families goes beyond assuring parents that their baby is fine and asking how breastfeeding is going, Carlson says. Pediatric hospitalists are key in identifying risks associated with poverty and substance abuse among patients and their families, as well as dealing with “life-altering issues,” he says.

Not only do pediatric hospitalists provide the initial care of the infant, but they also ensure that the parents are connected to sources of primary care and to other resources in the community when they leave the hospital. Patients’ and their families don’t leave without having arrangements for follow-up primary care, Carlson says. A discharge summary is provided for all infants, helping to foster communication with the pediatrician, if a family has selected one. The pediatric hospitalist can serve as the “in-hospital eyes and ears of the pediatrician,” he says.

There are 2.5 full-time equivalent (FTE) pediatric hospitalists at Barnes-Jewish Hospital and five FTEs at Missouri Baptist Medical Center. At Barnes Jewish, a teaching hospital, pediatric hospitalists work in newborn services in two-week blocks, because few pediatric hospitalists want to work exclusively in newborn services, Carlson says. The pediatric hospitalist group has developed clinical guidelines for infants with heart murmurs, infants of diabetics, infection surveillance, Group B sepsis, and Group B streptococcus based on its work at Barnes-Jewish Hospital.

**Patient load**

At Missouri Baptist, pediatric hospitalists work in an emergency pediatric center and in a pediatric inpatient unit. They also work with a neonatologist in Missouri Baptist’s Special Care Nursery to comanage ill or premature infants. Pediatric hospitalists provide around-the-clock coverage for the Special Care Nursery, Carlson says, noting that neonotologists work day shifts and are available only on-call after hours. Carlson says the staff there cares for eight to 12 normal newborns per day and comanages 10 to 20 infants in a special care nursery with a neonatologist.

A “reasonable model” for a community hospital, Carlson says, is a pediatric hospital medicine program that has six to 12 pediatric beds and performs 1,000–2,000 deliveries per year. At least 4,000 deliveries per year would be needed to support a pediatric hospitalist program for newborn services only, he says. Billing for services for the care of normal newborns is the same as it is by pediatricians in their offices, Carlson says. For the care of infants with medical conditions who may also be under the care of neonatologists, billing is bundled, he says.

According to a 2005–2006 survey conducted by the Society of Hospital Medicine (www.hospitalmedicine.org), 59% of responding hospital medicine programs (not including adult-only programs) offer newborn services. Of the 59%, 11% had started offering this service in the previous 12 months.

**Communicating with pediatricians**

Not all pediatricians are ready and willing to partner with pediatric hospitalists. In New York, at the Women’s and Children’s Hospital of Buffalo, John Pastore, MD, director of the pediatric hospital medicine program, says his program would like to provide newborn services. However, local pediatricians “tenaciously hold on” to their first visits to the nursery to evaluate newborn patients. It’s the first time they see a new patient and get to meet the family, Pastore says. As a result, many pediatricians are reluctant to give up the opportunity to begin a relationship with the patient and family in the hospital as soon as the baby is born, Pastore says. He adds that because of the dependable revenue from billing for newborn services, hospitals and...
Recruiting tip of the month: Finding quality candidates

Experiencing the recruitment blues? Finding quality candidates in today’s market can be particularly challenging as hospital medicine programs grow increasingly competitive and the nationwide physician shortage becomes more severe.

Note: A shortage of 200,000 physicians across all specialties is predicted by 2020. (Source: Cejka Search)

As a result, the successful recruitment of star hospitalists requires careful thought and execution through an organized search plan. However, a quarter of all organizations surveyed do not define what they are looking for in candidates before they begin searching.

First, engage senior leadership to help you define the core competencies (e.g., skills, motivations, and behaviors) of the position you are seeking to fill. Senior leadership can provide direction regarding the organization’s goals, which can then guide you in orchestrating a recruitment process. There are both short- and long-term organizational goals to consider, and they span multiple areas including clinical, operational, financial, and cultural. Finding the right physician to match your organization’s expectations requires sensitivity to factors inherent in the position.

For example, the greater the number of responsibilities of a position, the smaller the pool of candidates with the desired personal and professional qualifications will be.

Determining how a position fits your organization’s needs, critiquing the specifications and job descriptions, and ensuring that your team is properly trained to interview candidates can help your organization more successfully recruit top-quality hospitalists.

Editor’s note: For further reading on pediatric hospitalists, see “Pediatric Hospitalists Fill Varied Roles in the Care of Newborns” by Douglas Carlson, MD; Kathleen Fentzke, MD; and Jeff Dawson, MD, in Pediatrics Annals, 42:12, December 2003.

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Career satisfaction toolkit guides hospitalists in keeping jobs sustainable, avoiding burnout

If hospital medicine is to become a bona fide medical specialty, hospitalists’ careers must become more sustainable, so they are not “just passing through,” says Win Whitcomb, MD, director of the inpatient medicine service at Mercy Hospital in Springfield, MA, and cochair of the Society of Hospital Medicine’s (SHM) Career Satisfaction Task Force.

One sign that the field has work to do before joining the ranks of well-established medical specialties is that many hospitals’ medical executive committees (MEC) still do not include a representative from hospital medicine, Whitcomb says. “Hospitalists are not completely enfranchised yet,” he says. To earn seats on MECs, hospitalists must be perceived as seasoned professionals, he adds.

Burnout correlated with poor quality of care

An unintended consequence of the dramatic growth of hospital medicine is that hospitalists find themselves juggling unexpected and often unsustainable job responsibilities. Doing too much, not doing what they expected to do, and not doing enough of what they like to do can lead to hospitalist burnout, job hopping, and career dissatisfaction.

“Career satisfaction is not simply something that makes a hospitalist feel good,” says Whitcomb. “It’s also a quality of care and patient safety issue. Burnout is correlated with poor quality of care.” To help hospitalists and hospitalist leaders sort through the many factors that lead to career dissatisfaction or burnout, the SHM Career Satisfaction Task Force is developing a research-based toolkit that focuses on the following four domains identified as relevant to career satisfaction:

- Autonomy/control
- Reward and recognition
- Workload and schedule
- Community and environment

The toolkit will consist of detailed questionnaires and guidelines that hospitalists can use for self-assessments or for evaluating a new position. Hospitalist leaders can use the tools to manage their programs, develop job descriptions, recruit new hospitalists, and retain current hospitalists by making positive changes in the work environment.

Recognition, autonomy, solidarity

“What we are doing is trying to give individual hospitalists and those who design hospital medicine groups a set of tools to actually install career satisfaction,” Whitcomb says. In his own early research based on surveys of hospitalists (“Characteristics and work experiences of hospitalists in the United States,” Archives of Internal Medicine, 2001; 161:851-858; and “Thriving and surviving in a new medical career: The case of hospitalist physicians,” Journal of Health and Social Behavior, 2002), Whitcomb says he found that there are three major factors associated with burnout—lack of autonomy, lack of recognition, and lack of occupational solidarity. He describes occupational solidarity as being “part of a close-knit group of peer professionals who share in the joys and frustrations of a professional endeavor.”

If the three important pieces of satisfaction are in place—autonomy, recognition, and solidarity—Whitcomb says, “You can work pretty hard and not get burnt out.” Still, there is a limit to the work load that hospitalists can handle, which is the fourth area that the SHM task force seeks to address.

Toolkit

The task force solicited input from hospitalists on draft toolkit materials during the SHM annual meeting in Washington, DC, in May. The following are samples of the resources that made the cut:

1. Autonomy and control. A draft 29-item questionnaire asks hospitalists to rate on a scale of one to five the importance of autonomy and control over various aspects of work, including schedule, type of patient to admit or discharge, what diagnostic tests to order, workload volume, which unit they
work on, work interruptions, computer terminal availability, and free medications for needy patients. This questionnaire is intended to help hospitalists determine the areas of control that are important to them.

2. **Rewards and recognition.** Another draft section offers guidelines and recommendations to help hospitalist leaders reflect on whether their work environment provides adequate opportunities for recognition and poses questions such as the following:
   - Is the compensation commensurate with the workload and with compensation for similar positions in the marketplace?
   - Is the hospitalist treated like a glorified resident or an attending physician by primary care physicians/specialists?

3. **Community and environment.** This domain encompasses both the physical work environment and the social environment. The draft guidelines and recommendations explain that unresolved conflicts are destructive to the social fabric at work. The resource includes suggestions for building in time and opportunities for good communication within the hospital community, with other hospitalists, and with patients and families. Suggestions for improving the work environment include providing practitioners with adequate office/work space, ensuring that the technology they rely on is up to date, and dedicating time in hospitalists’ schedules for teaching and administrative roles.

4. **Workload and schedule.** Whitcomb says it is difficult to develop workload “ceilings” that can be broadly applied across hospital medicine programs because each is unique. With that in mind, the task force is likely to use the biennial SHM survey as the centerpiece for its recommendations on workload and schedule, Whitcomb says.

The survey produces data on patient encounters and other indicators of workload that will be valuable to the task force’s research and eventual recommendations. Whitcomb, a founder of SHM, calls his efforts in developing career satisfaction tools that can be broadly applied to hospitalists and hospital medicine groups the hardest work he has done for SHM.

“What makes one person satisfied in a career could be different for another person,” he says. Many variables—including one’s personal life; “local” characteristics, such as acceptance of the field by primary care physicians; and the support and understanding of the value of hospital medicine by medical leaders and administrators—can affect one’s career satisfaction, he says.

**Editor’s note:** According to SHM, there is no firm date for the toolkit’s release. Visit www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=3954 for more information about the SHM Career Satisfaction Task Force.
Patient portals: Using IT to connect with patients

Hospitalists are playing important roles in hospitals’ efforts to implement electronic medical records (EMR), which promise to dramatically enhance communication and information sharing among physicians and other healthcare professionals. But the patient is often the overlooked or “missing person” in this loop, says Jim Jirjis, MD, assistant chief medical officer at Vanderbilt Health System in Nashville, TN.

Jirjis and other representatives from Vanderbilt joined Daniel Sands, MD, who practices at Beth Israel Deaconess Medical Center in Boston and helped develop a patient portal “PatientSite” there, to discuss their experiences with patient portals during the June 30 HealthLeaders Media audio-conference “Bedside Browsers: Using IT to Connect with Patients.”

Health systems that have a patient portal currently stand out in the marketplace, but Jirjis says that before long this will become an expectation, similar to online banking. “I don’t know how many banks now can exist without offering online banking,” he says. Jirjis believes that integrating a patient portal into an EMR culture brings “true value” to the consumer. When patients have access to the same information as their physicians, it stimulates greater communication about diagnosis and treatment, he says.

“When you involve consumers in their care, it’s not only satisfaction that goes up, but also the quality of the outcome,” he says.

Patient portals often allow patients to e-mail physicians, access lab and test results, review and pay bills online, and access general health information that has been vetted by the health system. If your hospital is considering providing a patient portal, here are some important lessons learned from Vanderbilt Health System and Beth Israel Deaconess:

Access to records
Providing patient access to records immediately raises several loaded questions, including the following:
- What data should patients see in their records?
- When should they see it?
- What other individuals should have access?
- How should the records be presented?
- Does the aspect of educating patients outweigh the fact that it may make more work for healthcare professionals?

“Just because we have the technology and people have the legal right to see their test results, does that mean we should do it?” asks Jirjis. The role of the provider in confirming the accuracy of test results and providing a “contextual explanation of their meaning” has been at the core of an in-depth cultural discussion at Vanderbilt, Jirjis says.

For example, one patient’s chest x-ray showed a lower left lung mass on the Friday of a three-day weekend, he says. However, a computed axial tomography (CAT) scan had earlier detected a hernia. If the patient had had immediate access to the x-ray, she would have spent the weekend worried about a tumor instead of a hernia, Jirjis says.

At Vanderbilt, patients have immediate access to some results such as cholesterol, glucose, and pregnancy tests. There is a week-long delay to access x-ray results, which are more sensitive and may require the interpretation of a provider.

Sands says Beth Israel Deaconess has adopted “a spirit of openness” vis-à-vis patient access to records, but it also embargoes certain test results. There is a delay of two weeks for pathology test results (not including pap smears) to enable providers to review results and personally communicate with patients. There is also a 72-hour embargo on CAT scan results. Access to HIV test results is restricted, he says. While it has not been much of an issue with patients, the system also enables patients to see the audit trail (i.e., who has viewed their test results). Sands says patients do not have access to notes. About 16% of patients look at their records each month, he says.

“It is stunning to see what happens when a patient reviews records before coming to see the doctor,”
Sands says. “Some physicians understand that it is now a level playing field and that patients have access to the same information they do.” The difference, he notes, is that physicians can use their wisdom and experience to interpret the information.

E-mails to physicians
Physicians continue to be leery of being overwhelmed by e-mails from patients. At Vanderbilt, e-mails to physicians are first triaged by administrative staff who answer routine, nonclinical e-mails (e.g., messages about getting prescription refills). Many physicians are less resistant to patient e-mails if they know a triage system has been set up. Administrative staff can even print out e-mails for physicians who do not use e-mail and relay the physician’s response back to patients.

Based on the results from five Boston hospitals that use PatientSite, which went live in 2000, more than 25,000 patients are active users. Providers receive fewer than 20 messages each month per 100 patients, or less than one message per day for every 100 patients, Sands says, with requests for refills the most common subject, followed by requests for referrals and appointments. There are approximately 2.5–3 clinical messages sent per administrative message, he adds.

Sue Muse, project coordinator at MyHealthAtVanderbilt, says her system does a weekly audit at 5 a.m. every Wednesday to ensure that patient e-mails are answered in a timely fashion. If patients do not open their e-mails from providers, the messages are bounced back to staff, who then call the patient. E-mails are saved to the patient’s chart, she says. Some offices use e-mails to communicate test results, she says. One advantage of patient e-mails is that they cut down on the number of phone calls that must be made, she says.

“Most people send succinct messages,” says Jirjis. If patients abuse e-mail, they can lose their right to e-mail the provider, but this has only been done for one patient, he says. Jirjis says one goal at Vanderbilt is to encourage people to transition beyond e-mail, which is not secure and not always reliable, to become regular users of the patient portal.

Registration
To set up registration for a patient portal, hospitals must

- develop a process for patient registration
- develop a process for registration by physicians and practices
- stimulate patient interest in participating
- consider whether to allow proxy registrants (e.g., a son or daughter) to register on behalf of an elderly parent
- develop a policy for patients with no provider in the system

At Vanderbilt, when a patient registers for the portal, the system verifies that there has been a completed appointment with one of the providers on staff. One of the best ways to stimulate interest in using patient portals, Sands says, is to have physicians mention it to their patients. Some individual practices are even registering patients over the phone, he adds.

IT for inpatients
Angie Atema, a certified child life specialist at Vanderbilt Children’s Hospital in Nashville, TN, developed Vanderbilt Children’s GoFetch program, whereby Vanderbilt provides personal computers to pedi- atric inpatients, which enables them to maintain contact with friends and family members and keep up with their classroom work. Videoconferencing capabilities allow the children to be “present” in their classrooms and to see and be seen by their classmates, Atema says.

Children can create their own Web sites using a template, and friends and relatives can go to the site to find out more about the condition the patient has and read the patient’s messages.

Most adult patients are in the hospital for such a short time that this program may not be suitable for them, says Sands. It may be more suitable for bone marrow transplant patients or others who will have longer stays. Shared use of computers also raises infection control issues, he says.

Atema notes that Vanderbilt uses keyboard covers and screen protectors that are easy to clean.
Hospitals focus on handoffs to combat errors: SBAR checklist seen as one solution

The Wall Street Journal reported June 28, 2006, that growing evidence points to communication breakdowns during patient handoffs as the largest source of medical errors in U.S. hospitals.

Specifically, “longstanding cultural barriers” between physicians and nurses with regard to sharing patient information are blamed as one part of the problem.

A key driver behind the new, increased focus on improving patient handoffs is a recent mandate by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requiring accredited hospitals to have standardized mechanisms in place for handoff communications.

According to the article, many hospitals are beginning to use “homegrown” checklists and other protocols to comply with JCAHO, but others have had success using a system called SBAR, established by the military.

SBAR is an acronym for “Situation, Background, Assessment, Recommendation,” a process that when translated from military to healthcare takes practitioners through the following steps to help them quickly organize their thoughts and communicate key information about a patient’s situation:

- **Situation:** Describe the patient’s situation. In just a few seconds, get someone’s attention.
- **Background:** Provide enough background information about the patient to give the listener sufficient context for the current situation.
- **Assessment:** Give your assessment of the patient’s overall condition.
- **Recommendation:** Provide your specific recommendations.