To free beds for new admissions, triage best candidates for early discharge

A year ago, the 577-bed Baptist Hospital of Miami took two steps in an effort to improve patient flow and reduce patient boarding in hallways:
- It placed a hospitalist in its busy emergency department (ED) on a 24-hour basis to speed up hospital admissions of ED patients
- It set a goal of discharging patients by 11 a.m. to free beds earlier in the day

However, Tom Villanueva, DO, MBA, medical director of the hospitalist program at Baptist Hospital, says placing a hospitalist in the ED did nothing to improve patient flow and, in fact, may have worsened patient waits for a hospital bed.

The hospital handles 73,624 ED visits annually and sometimes admits as many as 40 ED patients in one day, Villanueva says.

“One dedicated hospitalist, because of sheer volume, cannot realistically evaluate all these patients,” he says. Villanueva says it takes a full hour to perform a history and physical and an evaluation of a patient before admission. If four or five patients are

Using the JCAHO’s six competencies to evaluate MD performance

Expectations that hospitals will use standardized indicators to measure practitioners’ competency and performance have increased as payers move toward pay for performance and consumers demand higher-quality care. Experts now anticipate that those expectations of data-driven measurement will eventually become requirements from the hospital industry’s leading accrediting agency, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The JCAHO’s 2007 Medical Staff Standards emphasize ongoing measurement of practitioner competency in six general categories:
1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

The six general competencies, which were originally developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties for measuring
Early discharge

waiting to be admitted by one hospitalist, there’s “even more of a pileup,” he adds.

Until a few months ago, the hospital was also not having much success with its second goal of discharging patients by 11 a.m. The hospital has nurses who work as patient care facilitators (PCF) to help coordinate patients’ care, schedule follow-up appointments, and gather lab and test results. A key part of the PCFs’ role is to do rounds with hospitalists to identify patients who will be ready for discharge the next day and get a running start on the discharge to-do list, with the goal being to discharge the patient earlier in the day.

Despite the best efforts of PCFs and hospitalists, delays in discharging patients persisted until a few months ago, when the PCFs and hospitalists changed their early-discharge priorities. Specifically, they started doing triage on discharges, says Villanueva.

**Triage patients ready for discharge**

Instead of focusing first on the more complicated discharges, such as those for patients being discharged to nursing homes or skilled nursing facilities (SNF), the hospitalists and PCFs began focusing their efforts on patients who could realistically be discharged by 11 a.m. One reason: No matter how early in the morning the team began working on the discharge of a patient to a nursing home or SNF, there were usually delays because of transportation and other issues. Now, 33% of discharges take place before 11 a.m., Villanueva says.

Patients who are in the hospital for a thoracic or cardiac procedure—or whose discharge is pending results of an international normalized ratio for Coumadin—are realistic candidates for early discharge, Villanueva says.

Early discharge of patients is essential to improving patient flow, says Bud Pate, director of clinical operations improvement for The Greeley Company, a division of HMA’s parent company, HCPro, Inc., in Marblehead, MA. Typically, about 15% of ED patients must be admitted to the hospital, he says, and demand for ED services gradually builds throughout the day, beginning at 11 a.m., peaking at about 7 p.m., and leveling off after 11 p.m. Freeing beds earlier in the day reduces patient boarding in EDs—or at least reduces the length of time that patients may have to be boarded, he adds.

**Dee Pete,** managing partner of InSight Advantage, a consulting firm in Houston that works with hospitals on patient flow issues, says that ideally 70% of patients who are pending discharge or are potential discharges should be discharged by noon.

How do you know whether patient flow is working well? From the time that a patient enters the ED, it should take 15 minutes or less until triage begins and 30 minutes or less for the patient to see a provider. For patients who are then discharged from the ED, it should take two hours or less. For patients who are admitted as inpatients following an ED visit, it should take no more than an hour from the time that admission orders are written to bed placement.

Some hospitals (e.g., Baptist Hospital of Miami) have started using so-called SWAT teams to facilitate early discharges, Pete says. Typically, nurse managers or unit-based case managers start working on paperwork, patient education, scheduling appointments, and arranging transportation the day before the patient’s anticipated discharge, so the patient can be discharged early. “That way, you have more operational functional capacity later in the day, which coincides with [increased] demand for beds from ED and . . . demand for surgical beds from the operating room,” Pete says.

To be effective, members of the SWAT team need to be “active, energetic, and have good critical thinking skills,” says Pete. In addition to the SWAT team members, a designated person should be accountable for ensuring that the facility’s discharge plan is consistently followed. In conjunction with a SWAT team, some hospitals have an “express” admission process that expedites patient admissions from the ED. Nurs-
es working on express admissions from the ED may prepare patients for admittance by obtaining and dispensing medication, administering IVs, and doing paperwork to make the transition easier on the inpatient nurses, Pete adds.

**Boarding patients on floor instead of ED**

At Memorial Regional Hospital in Hollywood, FL, Debbie Tedder, RN, MBA, chief nursing officer, says that her hospital treats a large indigent population and that as many as 30% of ED patients are admitted to the hospital, making patient flow a sizable issue. In December and January, the boarding problem at her facility reached a crisis level—patients were waiting six hours or more for a bed after receiving admission orders. “We could not move true emergencies through the department,” she says. As a result, Tedder says that instead of boarding patients waiting for admission in ED hallways, the ED staff began using a strategy that Pete refers to as the “adopt-a-boarder” or the “your-hallway-or-mine” method. The ED staff at Memorial Regional Hospital began sending patients to the appropriate hospital floors, even if there were no beds available.

According to Tedder, the hospital decided to place the pressure on the floor nurses to find a bed for patients, because it determined that the nurses had more control over bed availability than ED staff. In addition, the nurses are in touch with family members and have the ability to facilitate a discharge, she adds. “We decided to put the pain where [the] solution lies. The concept of hallway beds is scary to think about, but it was one of the most effective tools we had.”

She says the ED gives the appropriate units one hour’s notice that a patient is being sent to the floor. Designated areas in full view of the nursing station on that floor house the patients’ beds. “We felt it was safer to put the patient on the floors, even if they are in the halls,” she says, noting that the patient is assigned to a nurse on the floor who has greater accountability for the care of the patient. “In the ED, patients are not looked at and assessed the same as on a nursing unit. Orders are begun in an orderly fashion.”

Although the policy at Memorial Regional Hospital was no doubt unpopular with healthcare providers on the various floors, Tedder says it has been extremely effective. Once staff realized that the ED was serious about sending them a patient in an hour, a bed tended to “magically” appear, she adds. “We’ve never had to implement a hallway bed,” she says. “A bed has always become available.”

Educating physicians about the importance of early discharges is also important, Tedder says. At Memorial Regional Hospital, she and others have had conversations with the top admitting physicians about the importance of discharging patients early to free available beds. To address patient privacy issues, the hospital is purchasing screens to shield hallway-boarded patients, she adds.

Pete points out that hospital floors need to have portable equipment (e.g., oxygen and IV equipment) for patients in hallway beds. However, she advises that there should be no more than two designated hallway beds per unit.

“ED patients in the hallway do not receive the same standard of care as they would on an inpatient unit,” Pete says. She adds that the Joint Commission on Accreditation of Healthcare Organizations has reported that some sentinel events have occurred with ED boarders.

The focus in the ED is not on patients’ pending admission to the hospital but on being prepared for the next patient who will be coming through the door, particularly because facilities are adopting a no-diversion policy. “What personnel seem to forget is that the ED has no control over who comes into the front door,” Pete says. “Just because the ED has five critical patients, doesn’t mean paramedic traffic will stop.”

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“We decided to put the pain where the solution lies. The concept of hallway beds is scary to think about, but it was one of the most effective tools we had.”

—Debbie Tedder, RN, MBA
Six competencies  < p. 1

resident competency, provide a new framework for hospitals to evaluate practicing physicians, says Robert Marder, MD, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. HCPro is the publisher of this newsletter.

“The question is, how well does this framework translate to practicing physicians? It’s one thing to say, ‘This is what you need to become a physician, or certified as a physician,’ ” Marder says. “How well does it relate to current competency? I think it’s an interesting question.”

Despite the drawbacks associated with data collection that many hospitals currently face (e.g., difficulty attributing outcomes to the proper physician), hospitals should consider the following options for measuring physician competency in the six categories:

1. **Patient care.** The introduction to the credentialing and privileging section of the JCAHO’s 2007 Medical Staff Standards states that physicians are expected to provide compassionate, appropriate, and effective patient care for the promotion of health, prevention of illness, and treatment of disease, as well as at the end of life.

The expectation to measure both compassionate care and appropriate and effective care in each of the areas described above is problematic because it combines technical performance with the “soft” quality of compassion, Marder says.

“From a [human resources] standpoint, you would never lump together your interpersonal skills with your technical knowledge,” he says. “Part of the issue here is, when you try to measure these categories, some of them [require the measurement of] multiple things. That’s going to be a challenge for hospitals.”

Marder suggests breaking the three qualities (i.e., compassionate, appropriate, and effective) and the areas of care (i.e., promotion of health, prevention of illness, treatment of disease, and care at the end of life) into a three-by-four matrix to determine how to measure each element. For the qualities of care, Marder says the following types of measures can be used:

- **Effective = outcomes** (e.g., mortality rates)
- **Appropriate = processes** (i.e., core measures, such as angiotensin converting enzyme inhibitors on discharge for heart failure)
- **Compassionate = communication** with patients and families (e.g., informed consent)

Marla Smith, MHSA, a consultant for The Greeley Company, says facilities can use checklists of physician behaviors to measure compassionate care, such as whether the physician shakes the patient’s hand and explains the patient’s diagnosis or treatment options in a clear and understandable manner.

2. **Medical/clinical knowledge.** The JCAHO states that practitioners must “demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and apply that knowledge to patient care and educating others.”

“It’s fine in training to measure medical knowledge because you have a test,” Marder says. “Is the measure of medical knowledge that [a physician has] maintained board certification? That may be all you need.” Marder suggests that documentation of continuing medical education may also serve to measure competency in this category.

3. **Practice-based learning and improvement.** The JCAHO seeks proof that practitioners are able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

“This is going to be tough to measure,” Marder says, unless hospitals define practice-based learning as the implementation of core measures (e.g., participation in preprocedure timeouts). However, hospitals should only use core measures that are physician-relevant.

4. **Interpersonal and communication skills.** The JCAHO expects practitioners to demonstrate skills...
that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.

Marder suggests that incident reports of staff or patient complaints regarding physician interpersonal and communication skills could be used to document noncompliance. Another way to measure these skills involves surveys of staff and patients.

5. Professionalism. Practitioners are expected to demonstrate behaviors that reflect commitment to continuous professional development, ethics, and sensitivity to diversity, as well as responsible attitudes toward patients, the medical profession, and society.

One way to measure competency in this category could be to document incidents of disruptive behavior or other examples of noncompliance with professional or ethical codes, Marder says.

6. Systems-based practice. The JCAHO seeks evidence that practitioners demonstrate an understanding of the contexts and systems in which healthcare is provided and are able to apply this knowledge to improving healthcare. Examples of systems-based practice include patient advocacy and coordination of care between levels of care and among teams.

Marder says that competency could be measured based on utilization management data (e.g., correct use of resources such as blood transfusions, cooperation with patient safety practices, etc.).

Other measurements could include compliance with the Situation-Background-Assessment-Recommendation technique for communication between members of the healthcare team about:
- a patient’s condition
- preprocedure timeouts
- order read-back requirements

This expectation requires physicians to understand that they operate in a system with certain rules that take into account care beyond the physician-patient relationship.

“Sometimes, the system has to override how you would like to operate,” Marder says.

Using surveys to collect data

For the measurement of competency in “soft” (i.e., nontechnical) categories such as compassion, professionalism, and interpersonal and communication skills, hospitals may need to rely on patient or staff surveys for data.

“What you’re talking about is people’s perception, not hard data,” says Robert Marder, MD, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Hospitals should use perception data to measure soft categories. Marder says nurses and other staff are ideal for gauging physicians’ professionalism, communication, and other soft skills, although they should not be asked to rate physicians for clinical/technical quality, which can be assessed by more objective data.

A survey might ask patients, allied health professionals, residents, or other physicians to rank a physician’s professionalism, communication, or compassion on a five-point scale (e.g., very good, good, average, poor, or very poor). Surveys can also ask patients to agree or disagree with statements about a physician’s care (e.g., “The doctor kept me waiting,” or “The doctor expressed interest and empathy.”)

Data should be collected from a sample that is large enough to exclude any individual biases—although unbiased data can be difficult to obtain from patient satisfaction surveys.

Patient satisfaction surveys are nonetheless valuable, Marder explains. “Is it appropriate to get perception data to fill in the gaps? The answer is, ‘Absolutely.’ ”
Recruiting tip of the month: Fostering leadership potential

Leadership development for a physician requires a comprehensive approach and lasts throughout his or her entire career.

Hospitalist leaders can foster leadership in their organizations by proactively recruiting physicians with leadership potential.

To do this, first determine whether a candidate’s skills and knowledge meet your organization’s needs.

A well-constructed interview enables you to evaluate attitude, self-image, and social skills.

The interview process should look below the surface to assess the candidate’s motives, values, and key personality traits.

Traits to look for in physician leaders include:
- organizational agility
- integrity and values
- history of achievement
- motivation
- professional and personal goals
- interpersonal and communication skills
- ability to accept feedback and respond to coaching
- leadership experience and potential

Developing physician leaders

To target and develop leadership potential in a physician, the key is to start early. Immediately introduce physicians to the organization’s goals, mission, vision, and core values, and discuss how these align with those of the physician.

By clarifying expectations, the developing physician leader will better understand how his or her skills will help to lead the organization in multiple ways: clinically, as a business enterprise, and among peers and staff.

Ensure that up-and-coming hospitalist leaders understand the expectations and specific responsibilities related to their job description. Communication and ongoing feedback and support are essential and send the message that you want to nurture the careers of physician leaders. This helps to increase job satisfaction and retention.

Editor’s note: This tip was submitted by Paul Smallwood, vice president of physician search with St. Louis–based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information on recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800-678-7858.
Early results of Surviving Sepsis Campaign show significant reduction in mortality

Many healthcare providers have vivid memories of a patient that they suddenly lost to severe sepsis, such as a middle-aged surgery patient who died 24 hours after going into septic shock, or a young patient who came to the hospital with pneumonia and survived sepsis, but left with missing fingers.

According to the Institute for Healthcare Improvement (IHI), the mortality rates associated with severe sepsis are extremely high: 30%–50% for severe sepsis and 50%–60% for septic shock. An estimated 750,000 individuals in the United States develop severe sepsis annually. More patients die from it than breast cancer, lung cancer, and colon cancer combined, and the numbers are growing.

In 2003, critical care and infectious disease experts from 11 international organizations developed the Surviving Sepsis Campaign to promote the use of guidelines for the management of severe sepsis, with the goal of reducing sepsis deaths by 25%.

The campaign, in partnership with the IHI, promotes the use of two “sepsis bundles” of guidelines to reduce mortality (see sidebar on p. 9).

Tip: A “bundle” is a group of interventions that, when executed together, may result in better outcomes than when implemented individually, according to Sean R. Townsend, MD, a faculty member at IHI and assistant professor of medicine at Brown University and Rhode Island Hospital, both in Providence.

The campaign’s six-hour Severe Sepsis Resuscitation Bundle describes five to seven steps that healthcare practitioners should take within the first six hours after a patient presents with severe sepsis or septic shock. The 24-hour Sepsis Management Bundle lists four management goals that practitioners must complete within 24 hours after a patient presents with severe sepsis or septic shock.

Early resuscitation of patients is key

Ron Rains, MD, director of critical care at the Memorial Health System in Colorado Springs, CO, says a coalition of 16 hospitals in the state came together to implement the sepsis bundles.

About 10 of the hospitals have been submitting data, says Rains, who is chair of the Colorado Critical Care Collaborative. The coalition has so far collected data on 500 patients.

At the start of the initiative in early 2005, Rains says mortality from severe sepsis in the coalition hospitals was similar to the 35%–40% seen at most community hospitals. The Colorado data indicates that with use of the sepsis bundles, mortality has dropped to 20%–22%, a 40% decrease.

One reason for this dramatic decrease, according to Rains, is that the sepsis bundles initiative has helped focus hospitals on early recognition and treatment of severe sepsis patients. If treatment is not started early, “you’ve lost a significant potential impact,” Rains says.

“By looking for [sepsis], you find it,” he says. The initiative has put the focus on resuscitating septic patients with fluids, antibiotics, and vasopressors, if needed, in the first six hours after diagnosis.

A key step is to convince your emergency department (ED) that delays in identification and treatment of severe sepsis are a problem, Rains says.

In fact, some hospitals have identified early ED recognition of severe sepsis as a process improvement area. Rains adds that it’s essentially impossible to implement the sepsis bundles without early recognition in the ED.

“If sepsis is not recognized in the ED, then there is a substantial lag in initiation of the bundles, and you are noncompliant [with the guidelines]
Surviving sepsis

because the patient has been in the hospital for more than six hours," he says.

In the participating Colorado hospitals, more than 60% of severe sepsis patients are identified in the ED. Rapid response teams have played an important role in early identification and treatment of septic patients. And, just as hospitals added stroke and heart attack alerts when evidence mounted that timely treatment of these patients improved outcomes, some hospitals are now adding sepsis alerts, says Rains.

Another factor in the dramatic decrease in mortality, Rains says, is that patients are probably getting more fluids earlier. There’s often a “concern that the patient will be getting too much fluid, but they tend not to have enough,” he says. Some providers gauge the need for fluid by blood pressure and urine output, but these measures are relatively insensitive.

“An oxygen deficit may go unrecognized at bedside,” Rains says. When using the sepsis bundles, providers rely on measures of serum lactate levels, which are a more sensitive indicator of inadequate tissue oxygenation, he adds.

Insertion of catheter
Townsend says that hospitals should follow all steps within the two bundles to achieve optimal patient outcomes.

One of the most problematic compliance issues is insertion of a central venous catheter to monitor central venous pressure and central venous oxygen saturation for patients who remain hypotensive after initial fluid resuscitation. Townsend says that, based on data collected by the Colorado hospitals, incomplete compliance with the protocol is often related to providers not inserting that line.

ED providers may be too busy to insert the line, which takes about 45 minutes and requires continuous monitoring. Or a physician may not be comfortable inserting the line and relies on the surgical team or on a consult to do so. Townsend notes, however, that physicians who complete training in either emergency medicine or internal medicine have passed clinical competencies to insert these lines.

Townsend draws a parallel to the initial resistance of practitioners to the use of thromboembolitics in the treatment of myocardial infarction years ago, a protocol that has now become standard treatment in the ED when cardiac catheterization is not available. Insertion of a central venous catheter is a similarly important step to achieving dramatic results in the treatment of severe sepsis, he says. “I hope we reach the point where if I told you these key parameters were not checked, I would receive the same puzzled glances as if I failed to offer thrombolytic therapy for an ST elevation MI. The mortality differences will prove to be similar over time,” he says.

Rains says insertion of the central venous catheter is “the hardest part of the whole thing. ED physicians aren’t always comfortable placing the catheter and the intensivist may be tied up. Willingness to take the time to place the catheter is a roadblock.” There is also pushback from ED nurses who are uncomfortable using the monitor and do not want responsibility for calibrating it. As a compromise solution, a central line can be used for checking...
venous oxygen saturation, he says. Making the decision to perform an invasive procedure is easier for some patients than for others. If the patient is still hypotensive and has lactate acidosis after initial resuscitation efforts, it is a more straightforward call to insert the catheter, he adds.

The problem comes with the more borderline patients who fall between those who are responding well to early resuscitation and those who clearly are not. Rains says that all of the steps of the two bundles are evidence-based. But he believes that further research may reveal that some steps are more important than others.

**Role of hospitalists**

Rains says that hospitalists are important in identifying the 40% of severe sepsis patients who do not come into the hospital from the ED and who manifest signs of severe sepsis on the floors. One of the challenges of identifying and treating severe sepsis, and of implementing guidelines for its

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**Sepsis bundles outline steps for care of severe sepsis in first six hours and in 24-hour period**

The Sepsis Resuscitation Bundle is a six-hour bundle of guidelines that should be followed in the first six hours after identification of a severe sepsis patient.

The Sepsis Management Bundle is a 24-hour bundle of guidelines that should be followed in the first 24 hours of care.

Go to [www.Survivingsepsis.org](http://www.Survivingsepsis.org) for more information about the Surviving Sepsis Campaign.

To request a complimentary copy of the campaign’s full guide to implementation and free campaign database software, email info@survivingsepsis.org with your name and mailing address.

### Sepsis Resuscitation Bundle

(To be accomplished as soon as possible, with measures scored over first six hours):

1. Serum lactate measured
2. Blood cultures obtained prior to antibiotic administration
3. Broad-spectrum antibiotics administered within three hours of presentation for emergency department (ED) admissions and one hour for non-ED intensive care unit (ICU) admissions
4. In the event of hypotension and/or lactate > 4 mmol/L (36 mg/dl):
   - Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent*)
   - Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) > 65 mm Hg

### Sepsis Management Bundle

(To be accomplished as soon as possible and scored over first 24 hours):

1. Low-dose steroids* administered for septic shock, in accordance with a standardized ICU policy
2. Drotrecogin alfa (activated) administered, in accordance with a standardized ICU policy
3. Glucose control maintained > lower limit of normal, but < 150 mg/dl (8.3 mmol/L)
4. Inspiratory plateau pressures maintained < 30 cm H2O for mechanically ventilated patients

*See the individual chart measurement tool for an equivalency chart.

**Achieving a mixed venous oxygen saturation (SvO2) of 65% is an acceptable alternative.
treatment, is that sepsis has a variety of pathways and occurs in a variety of settings, Townsend says. It can develop as a result of trauma, pneumonia, urinary tract infections, surgery, pyelonephritis, etc. Rains says that sepsis “is a nebulous term” and that it “crosses so many disciplines, it’s [hard] to characterize.” It affects many different organ systems in many different ways.

Townsend says hospitalists can be instrumental in the early identification of severe sepsis patients on the floor. Hospitalists can help initiate early management of severe sepsis, as outlined in the bundles, before the patient is sent to the ICU. “If we could get hospitalists to proactively identify patients with severe sepsis and begin resuscitation before transport to the ICU, an untold number of lives could be saved, and morbidity would be drastically reduced. This is not happening now,” says Townsend.

Challenging implementation
“It’s a lot of work,” says Barry Evans, RN, MSN, adult critical care data coordinator at the University of Rochester (NY) Medical Center, referring to the implementation of the Surviving Sepsis guidelines. “What you need most is patience.” Evans says she has been promoting use of the guidelines at her institution for the last three years. It took two years to get ED physicians interested in adopting the guidelines, and she is now working with critical care providers on implementing them. She also notes that it took a year to develop the related order sets because multiple committees at the University of Rochester Medical Center had to review them.

Andrew Rudmann, MD, chief of the hospital medicine program at Strong Memorial Hospital, which is part of the University of Rochester Medical Center, says that hospitalists at Strong Memorial have yet to begin working with the sepsis bundles guidelines.

Patients may not appear critically ill
According to Evans, some patients who come into the ED may not appear to be very sick. “Patients [in sepsis shock] don’t appear as acutely pressing as trauma or heart attack patients,” she says. They frequently present with only low dehydration or fever.

However, says Evans, “They are just as sick—just not as demanding of acute services.” With the surviving sepsis guidelines, there is greater awareness and recognition of severe sepsis in patients and, ideally, earlier intervention by practitioners, she adds.

Standardization of care is another area aided by the guidelines. “Providers each have their preferences and their own ideas of how to treat septic patients,” says Evans. Although practitioners already are aware of the importance of administering fluids and antibiotics to septic patients, they use a variety of other interventions, she says. Again, the use of standard guidelines would ensure that all patients receive evidence-based therapy, she adds.

Sepsis bundles outline steps for care of severe sepsis in first six hours and in 24-hour period
The Surviving Sepsis guidelines are built on early goal-directed therapy and include end points to help guide clinicians at bedside. A landmark study published in the New England Journal of Medicine in 2001 found that use of early goal-directed therapy reduced mortality in severe sepsis patients by 16%.

Editor’s note: For more information on the Surviving Sepsis Campaign, visit the IHI’s Web site at www.ihi.org/IHI/Topics/CriticalCare/Sepsis/Changes.

Questions? Comments? Ideas?

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A top-10 list is a time-tested tool for winning the attention of your target audience, whether it is composed of music fans, magazine readers—or healthcare administrators. At Strong Memorial Hospital in Rochester, NY, hospitalists use a list of top-10 diagnosis-related groups (DRG) to constantly reinforce the message that hospitalists bring value to the hospital through overall reduction of costs and patients’ decreased length-of-stays (LOS). Every month, Strong Memorial’s hospitalist service produces a chart (see below) containing the

- top-10 DRGs for that month
- number of patients treated for each DRG
- average LOS
- average cost per patient

The hospitalist program then compares the hospitalists’ monthly DRG statistics with those for both primary care physicians (PCP) who treat patients in the same hospital and for physicians in the nationwide University Hospital Consortium (UHC), a group of 55 academic medical centers. Andrew Rudmann, MD, chief of the hospital medicine division at Strong Memorial, says the service began producing the monthly report in January at the suggestion of then-department chair Bradford Berk, MD, PhD, who is now the senior vice president for health sciences and CEO of the University of Rochester (NY) Medical Center. Although the list gives the hospital medicine program feedback on its own performance, its main purpose is to remind the chief operating officer (COO) and other administrators of the value that the program brings to the hospital. Rudmann says he presents the chart to the COO and the hospitalist advisory group during a monthly meeting.

In the most recent chart, hospitalists had shorter LOS and lower costs for all DRGs except for septicemia and chronic obstructive pulmonary disease (COPD) when compared with PCPs and UHC physicians. The chart shows that hospitalists at Strong Memorial on the whole are performing well, and that based on costs and LOS data, they excel at treating patients for substance abuse and drug overdose, says Rudmann.

To collect the data, Rudmann simply asked for assistance from the hospital IT department. He worries, however, that as the number of PCPs treating patients in the hospital declines, he will gradually lose his control group.

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<tr>
<th>Medicare DRG description</th>
<th>Hospitalist Total cases</th>
<th>Nonhospitalist Total cases</th>
<th>Hospitalist Variable cost per case</th>
<th>Nonhospitalist Variable cost per case</th>
<th>Hospitalist SHM-adjusted LOS</th>
<th>Nonhospitalist SHM-adjusted LOS</th>
<th>UHC ALOS</th>
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<td>3.9</td>
</tr>
<tr>
<td>8 DRG 174 GI hemorrhage</td>
<td>61</td>
<td>50</td>
<td>$4,854.00</td>
<td>$6,082.00</td>
<td>5.4</td>
<td>6.0</td>
<td>4.3</td>
</tr>
<tr>
<td>9 DRG 296 Nutritional and metabolic disorders</td>
<td>55</td>
<td>62</td>
<td>$4,838.00</td>
<td>$5,947.00</td>
<td>8.5</td>
<td>9.5</td>
<td>4.3</td>
</tr>
<tr>
<td>10 DRG 416 Septicemia</td>
<td>49</td>
<td>60</td>
<td>$10,582.00</td>
<td>$9,270.00</td>
<td>10.8</td>
<td>9.7</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Note: Data qualified on: 1) 01 medicine program; 2) Hospitalist and nonhospitalist subspecialty; 3) Date of discharge=01/01–07/31/2006
Key: SHM = Society of Hospital Medicine; UHC = University Hospital Consortium; ALOS = adjusted length of stay
Source: Strong Memorial Hospital hospitalist program.
Tips for hospitalists who serve as expert witnesses

An article in the July issue of The Hospitalist, published by the Society of Hospital Medicine, offers advice for hospitalists who are approached about testifying as expert witnesses in medical malpractice cases.

Careful consideration of the hospitalist’s duties—applied to the specific case—should guide his or her decision to participate, the article states.

Defining the “standard of care” and determining whether the defendant(s) deviated from it is at the heart of many malpractice cases, according to the article. A jury’s only avenue for determining the standard of care is to hear experts’ opinions and make a decision based on their testimony.

As a result, hospitalists who participate as expert witnesses should testify solely to what they determine to be the appropriate standard of care.

To read the entire article, go to www.wiley.com/WileyCDA/Section/id-292144.html.

Hospitalists have great potential

As competition between hospitals heats up and as healthcare moves toward pay for performance, hospitalists have the potential to play a big role in helping their facilities improve patient care, according to an August 29 column in HealthLeaders magazine written by Chris M. Nussbaum, MD.

Nussbaum, founder and CEO of the Tampa Bay, FL-based hospitalist company Synergy Medical Group, writes, “The nature of the job means hospitalists are able to embed themselves in the culture of the facilities in which they work while they navigate the complex hospital care environment.”

Other added-value services that hospitalists regularly provide, writes Nussbaum, include covering emergency department call and providing consultation to patients of other surgical and nonsurgical physicians.

To access the article, go to www.healthleadersmedia.com/view_feature.cfm?content_id=82773.