A (really) Brief History of (PHM) Time

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The Landmark Article

  - Ideal of Primary Care Provider who cares for patients in all settings *versus*
  - Reality of competing demands of efficiency in inpatient and outpatient settings while providing quality care
Theory

• Better care through better ability
• Better care through better availability

• “The need to hospitalize a child is dependent upon the special services which the child requires rather than upon the diagnosis.”

A Proposed Academic Model

- Similar to intensivist
- QI
- Practice guidelines
- Outcomes research
- Consultation
Obstacles

- Decreased house staff autonomy
- Different kind of teaching
- Defining new specialty
Hospitalist Definition

• Physicians who spend at least 25% of their time serving as the physician of record for hospitalized patients who have been referred by primary care physicians and who are referred back to their primary care physicians at the time of discharge1

PHM Organizations

• Society of Hospital Medicine
  – Founded 1997 as National Association of Inpatient Physicians
  – Starts with 23 members including Pediatricians
  – 2012: ~10,000 members (6% Pediatric)

• AAP Section on Hospital Medicine
  – Provisional status in 1999
  – Over 1000 members

• APA Hospital Medicine SIG
  – Founded 2001
PEM Analogy

- Field
- Fellowships
- Boarding
- Fellow Conference
- Steve Ludwig
Concurrent Forces

- Pediatric inpatients are:
  - Sicker
  - more complicated
  - Require more services
- Pediatric Bed Crunch
- Focus on Quality of Care
Practice makes perfect

• Better care through better ability and availability
  – Clear correlation between surgical procedure volume and outcomes
  – HIV care
  – Adult cardiac care
  – Asthma care
  – Intussusception
More Care ≠ Better Care

• Fisher ES et al. Variations in the Longitudinal Efficiency of Academic Medical Centers. Health Aff 2004
  – Increased intensity of care proportional to increased availability
  – Increased intensity of care not related to improved outcomes
Hospitalist care is better

- **Internal Medicine**
  - Decreases LOS
  - Improves morbidity/mortality
  - Decreases readmissions
  - Decreases tests
  - **Definite Learning curve**

- **Pediatrics**
  - Limited, but similar experience
Standardization of care


  – Hospitalists more likely to adhere to evidence-based therapies and less likely to use unproven therapies and tests
Coordination of Care

• Huddleston J. Medical and surgical comanagement after elective hip and knee arthroplasty. Ann Intern Med 2004
  - Randomized, controlled trial of ortho care v. comanagement, 526 patients
  - Comanagement had less complications and preferred by surgeons and nurses

  - Decreased LOS

• PEWS and RRT– mult studies demonstrate benefits of early recognition of decompensation
Bottom Line

• Impact on real outcomes unclear
  – Hard to extrapolate from adult data because of significant differences of pediatric illness
  – Most studies to date are single system
  – Larger studies fail to account for differences in practice and patient acuity

• Does it pay?
  – No and Yes
Teaching

- Expand role of attending rounds – FCR – and beyond
- Synergy with ACGME competencies
- Compliance with work-hours restrictions - handoffs
Family Centered Rounds

- Includes family, nurses, physicians and other allied health personnel relevant to the particular patient's care and involves the patient and family in decision making
- Cited by the AAP as the preferred model of rounds
- Extremely prevalent
- More efficient and improved patient satisfaction
Teaching vs Service

- ACGME work hours restrictions
  - New for 2011
- Accumulating evidence on effects of fatigue
- Shifts and handoffs
  - iPASS
Where are/were we now/before?

  - 116 Ped Hospitalist Program leaders surveyed
  - Cover inpt service, consults, subspecialty pts, newborns, ED, PICU, NICU
  - 89% teach
  - 39% measure outcomes
  - Avg employment <3yrs
    *remember learning curve
How does it work?

- Many Models
  - 9-5 or 24/7
  - “Nocturnists”
- Should be voluntary
- Communication essential
- Ground rules essential
Can we do without it?

• **2012 Hospital Specialty Scores by Honor Roll Ranking**
  – 1 Children's Hospital Boston
  – 1 Children's Hospital of Philadelphia
  – 3 Cincinnati Children's Hospital
  – 4 Texas Children's Hospital, Houston
  – 5 Children's Hospital Los Angeles
  – 6 Seattle Children's Hospital
  – 7 Children's Hospital Colorado
  – 7 Nationwide Children’s
  – 9 Children's Hospital of Pittsburgh
  – 9 Lurie Children’s Hospital of Chicago
  – 9 St. Louis Children's Hospital
  – 9 *Johns Hopkins
Definition Revisited

- Society of Hospital Medicine (SHM)
  - Physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to Hospital Medicine.

- Broader definition than just clinical activity
  - allows for research
  - more consistent with that of a new specialty
A New Specialty?

- Joint Council of Pediatric Hospital Medicine
  - Umbrella Governance group
  - Coordinate activities of national organizations
A New Specialty?

• Meetings
  – Pediatric section at SHM annual meeting
  – SOHM sponsored presentations at NCE
  – APA SIG and Hospitalist theme at PAS
  – Pediatric Hospital Medicine now annual
    • 2013 meeting August 1-4 in New Orleans
  – Multiple regional meetings
    • 1st NYC meeting March 24, 2011
  – 1st Fellow’s Conference, Houston, TX Oct 1-3, 2011
A New Specialty?

• Textbooks
  - Pediatric Hospital Medicine 2003, 2nd ed 2008
  - Comprehensive Pediatric Hospital Medicine 2007

• Journals
  - The Journal of Hospital Medicine – 2006
  - Hospital Pediatrics
  - PREP: PHM – coming 2013

• PHM Core Competencies
Hospitalist Fellowships

- PRIS survey – acting hospitalists believe in need for additional training at fellowship level
- AAP survey 2007 – residents don’t want 3 yrs more
- 20 current fellowships
- ABP RP3 project
• PHM Vision Goals
  – We will ensure that care for hospitalized children is fully integrated and includes the medical home
  – We will design and support systems for children that eliminate harm associated with hospital care
  – We will develop a skilled and stable workforce that are the preferred providers of care for most hospitalized children
  – We will use collaborative research models to answer questions of clinical efficacy, comparative effectiveness, and quality improvement, and we will deliver care based on that knowledge
  – We will provide the expertise that supports continuing education in the care of the hospitalized child for pediatric hospitalists, trainees, midlevel providers, and hospital staff
  – We will create value for our patients and organizations in which we work based on our unique expertise in PHM clinical care, research, and education
  – We will be leaders and influential agents in national health care policies that impact hospital care
Next Steps

• Further research
  – PRIS – eliminate limitations of single institution generalizability
  – Cost – direct and indirect
  – Resource utilization
  – Quality of care
  – Experience with care by patients, referring providers, and hospital staff

• Program Development

• Faculty Advancement
Next Steps

YOU!
Conference Goals

• Networking
  – We want to meet you AND we want you to meet us
  – More important: we want you to meet each other!

• Some tips on career development

• An appreciation for becoming a hospitalist