Functional Variability Among Hospitalist: Optimizing Performance and Outcomes

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Background: Health care delivery teams led by hospitalist have been promoted as the best model to provide inpatient care. Most hospitals in the USA utilize this model expecting to improve safety, increase associate and patient satisfaction, decrease length of stay and reduce cost. There are multiple reports in the literature which confirm the advantages and benefits of this model. There is, however, a growing body of evidence disputing these claims and highlighting the negative impact of this model on patient care.

Objectives: Find out a possible explanation for these conflicting reports, determine whether the flaws are in the model itself, or the way the model functions, and propose several interventions to optimize performance.

Methods: We developed a functional profile for hospitalists covering medical-surgical units in a teaching environment where a resident is part of the team, and non-teaching environment where there are no residents. The profile was developed based on a blinded observation of the hospitalists during their shift hours and oral interviews with various members of the health care team. After completing the initial observation, the study was repeated. This time the hospitalist was informed that they were being observed.

Results: There were significant differences in how the hospitalist functioned on teaching units when compared to hospitalists on non-teaching united and between employed and non-employed hospitalists. Hospitalists on teaching units and those who were employed were less likely to provide consistent, ongoing assessments of patients during rounds, less likely to be physically on the unit after the rounds are completed to address nurses' and patients' concerns, and more likely to rely on the residents' evaluation and telephone communications. Handoffs were more likely to be unstructured and communication with referring physicians was poor. Hospitalists were judged to be overconfident, relied on memory to mange patients, and seldom used electronic decision support systems. There was a significant change in behavior after the hospitalists became aware of the observation. All Hospitalists examined and assessed the patients regularly and consistently. Communication with team members improved dramatically. Many hospitalists exhibited a low interest in teaching, and some exhibited poor teaching skills. Upon review of the literature, it became evident that the conflicting reports were largely due to a significant variability in function, driven by the level of expertise, experience, job expectations and requirements, and employment models which could create conflicts of interest monitoring improved performances.

Conclusion: Variability in hospitalists' performance is due to a variability in function. This variability in function is the result of several factors, many of which are not controlled by the hospitalists. While hospitalist behavior is not necessarily a cause for medical error, behavior could play a key role in preventing errors.

Recommendation:

- Recruitment of experienced Hospitalists
- Clear job requirements
- Contractual agreements that do not create a conflict of interest
- Structured handoffs and collaborative processes between hospitalists, nurses and referring physicians
- Ongoing CME and exercise of clinical reasoning and teaching skills
- Separate teaching function from the clinical function
- Ongoing monitoring.

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