



Hospitalist: A Focused Review

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Hospitalist practice is a significant part of inpatient care, and hospitalists have one of the most complicated roles in acute care. They interface with patients and families daily and assist in most aspects of specialty care. There is no single prescription for risk reduction, but it is our hope that you will find this review useful for identifying risk areas and developing risk mitigation strategies.

In this data study:

This review of claims is intended to identify systemic risks for hospitalist practice that led to adverse outcomes. 20 CAP closed claims involving hospitalists in which indemnity was paid were reviewed. This is not a comprehensive study but it provides insight into the cause of adverse outcomes and assists with the development of targeted education to increase patient safety, reduce risks, and protect physicians.

CASE STUDY MEDICATION ERROR

A morbidly obese male patient in his late 50's with metabolic syndrome was admitted by the hospitalist through the Emergency Department with shortness of breath and leg edema. He remained through the next shift in the ED Telemetry holding area, pending a bed. The hospitalist presumed that he had Congestive Heart Failure (CHF), though tests revealed decreased kidney function and an extremely enlarged heart. The hospitalist ordered Lovenox, Lasix, Albuterol and a beta-blocker. When the patient's heart rate increased, he ordered Labetalol. The patient was admitted after the hospitalist left and soon developed increased shortness of breath (SOB), diaphoresis, and hypotension, coded and expired.

ANALYSIS

1. The hospitalist did not recognize the patient's general poor condition and should have ordered a cardiology consult because of the enlarged heart and possible CHF. A cardiologist would not have prescribed Labetalol because it can cause hypotension and seizure, and would likely have admitted the patient to ICU. This could be considered a knowledge deficit, but it is also a missed communication opportunity.
2. The hospitalist left prematurely without communicating with the Emergency Department Physician (EDP) or the subsequent hospitalist.
3. The lack of communication led to an overall lack of awareness of the seriousness of the patient's condition.

CAP Data: 2006-2015

Closed Claims Reviewed¹

INDEMNITY PAID	\$7,636,547
AVG INDEMNITY PAID	\$381,827
EXPENSES PAID	\$1,100,175
AVG EXPENSES PAID	\$55,008

ALL DEFENDANTS

TOTAL EXPENSES	\$8,736,723
AVG TOTAL EXPENSES	\$436,836

General Allegation	Allegation Detail	# Claims	Indemnity Paid
Treatment related, indemnity paid: \$3,231,498 (Number of Claims 10)	<ul style="list-style-type: none"> • Delay of treatment • Improper performance of treatment • Improper management of treatment • Premature end of treatment 	4 2 2 2	\$1,700,000 \$529,999 \$921,500 \$79,999
Diagnosis related, indemnity paid: \$3,595,049 (Number of Claims 7)	<ul style="list-style-type: none"> • Failure to diagnose • Delay of diagnosis 	4 3	\$1,610,000 \$1,985,049
Medication related, indemnity paid: \$810,000 (Number of Claims 3)	<ul style="list-style-type: none"> • Wrong medication • Wrong medication dose 	2 1	\$310,000 \$500,000

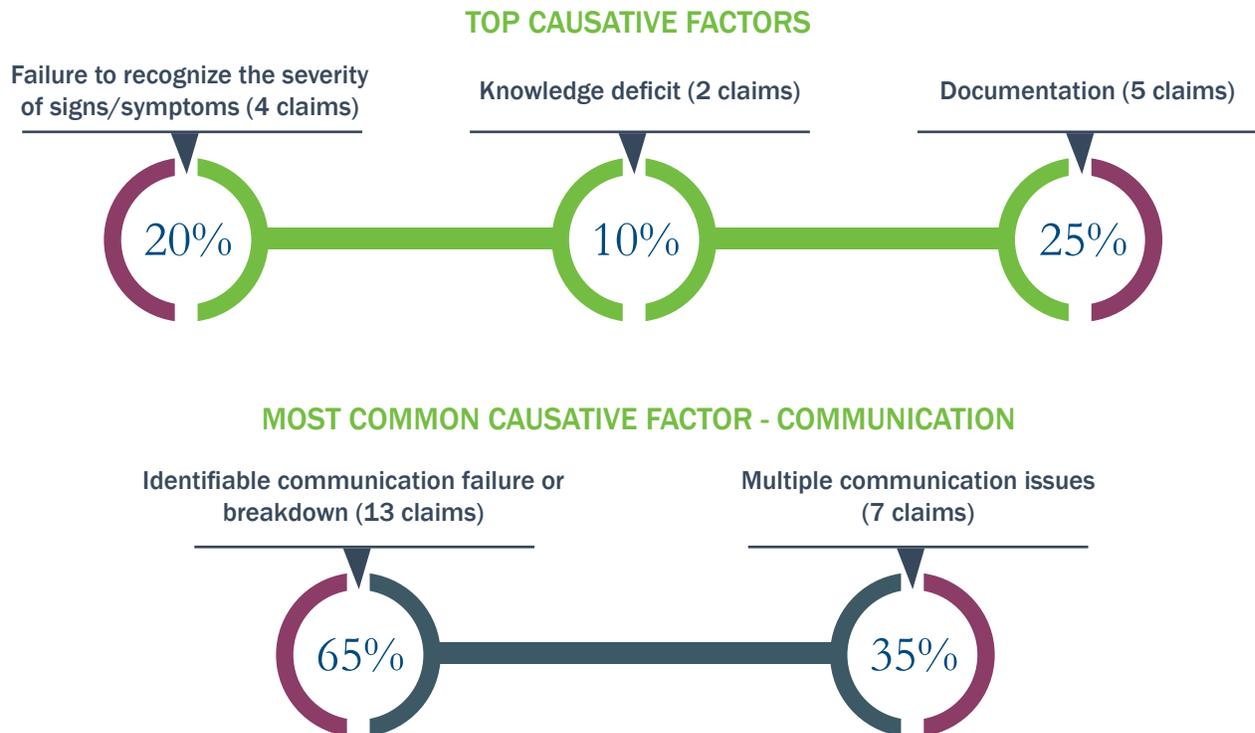
¹The indemnity amounts reported here were for only the hospitalist defendants. Most of these claims involved multiple defendants, specialists, hospitals and other hospitalists.

Causative or Contributing Factors

Most adverse outcomes have multiple causes and fit the Swiss Cheese Model developed by Dante Orlandella and James T. Reason. Normally, there are multiple layers of defense that prevent an adverse outcome. When failures occur, the layers line up like the holes in swiss cheese and the events “slip through,” resulting in the adverse outcome. For example, though a claim was categorized as a medication error, there may have been multiple underlying causes: documentation, fatigue, workload,

communication error, knowledge deficit, technology issues², etc.

Review of the claims revealed underlying causes that can be used to improve processes and prevent adverse outcomes. Because communication was such a common factor, focus will be on communication process improvements, though each of the other areas are worthy topics.



Communication Opportunities

What makes hospitalist practice different? What are the high-risk communication areas that can cause adverse outcomes and lead to claims? Improvement in the following areas can help prevent communication errors, adverse outcomes and claims.

Emergency Department Physician (EDP)/Hospitalist Communication

High risk “gray zones” of communication between hospitalists and ED physicians:

- 1. Incomplete diagnostic work-up** while in the ED with tests and studies still pending.
- 2. Unclear patient status** during pending admission with joint decisions between the EDP and the hospitalist.

- 3. Ambiguous physician responsibility** during admission while the patient is being boarded in the ED awaiting an inpatient bed.

Most of these issues are related to the competing priorities between the ED physician’s need to stabilize and transfer the patient as quickly as possible, and the hospitalist’s concern for long-term care and treatment options.

It is crucial that the admitting hospitalist work with the EDP to obtain all necessary information. Shift changes can be particularly problematic because of ED hand-offs that also affect hand-offs from EDP to hospitalist. A solid process is required to assure adequate communication.

²A true Root Cause Analysis requires a deeper dive into why each of these contributing factors occurred and is beyond the scope of this review.

Physician/Nursing Staff Communication

To improve physician/nurse communication, recognizing the importance of teamwork is key. Responding promptly to calls and encouraging mutual communication is important, as patient safety depends on these communications. A well-defined communication process such as SBAR (Situation, Background, Assessment, Recommendation) might be of value.

Intradisciplinary Communication, Doctor-to-doctor

Face-to-face communication with other physicians can be logistically hard to achieve. Thus, the medical record often becomes the sole means of communication. This makes documentation crucial and fraught with risk depending on the thoroughness of the recorder. Risk reduction can be accomplished through promotion of doctor-to-doctor communication regarding pending tests and other significant findings.

Documentation is one of the most important underlying issues. Not only is it frequently the only means of communication, it is also the foundation of claims defense. Remember the adage: if it's not in the chart, it didn't occur.

Communication of Diagnostic Test Results

Communication of diagnostic test results is not solely a hospitalist issue. Hospitalists, just like other physicians,

are responsible for follow up on their orders as exemplified by the simple adage: if you ordered it, you own it. The real issue facing hospitalists today is the nature of their work as shift work. Errors often occur when one hospitalist orders a test while another hospitalist may be on-call when results are received. Standard of practice dictates that the ordering physician is still responsible for reviewing the results and properly coordinating care unless otherwise noted in the record. Errors also occur at discharge when pending test results are overlooked. As seen in the case study below, the patient's outstanding HIV test result was filed in the medical record after discharge, and no one notified the patient. Having a well-established process for checking your EMR inbox, communicating with other hospitalists and appropriate specialists, and assuring that there was (or will be) proper follow up, is important.

Discharge Communication

Nearly half of discharged patients experience an error in medication continuity, diagnostic work up, or test follow-up³. These errors are mostly due to failures in communication. A pre-discharge protocol, discharge planning, structured patient education, written patient instructions, and post-discharge follow-up processes should be developed and in place.

CASE STUDY DELAYED DIAGNOSIS

The following case illustrates an adverse event and not a claim. It provides a good example of how communication failures can cause delays in diagnosis. In this case, a 26 y.o. female with a history of depression and bipolar disorder was seen in the ED for acute abdominal pain, fatigue and loss of appetite. She admitted to a history of illicit drug use and engagement in high-risk sexual contact so the EDP ordered a full STD panel with HIV test before hospitalist #1 admitted the patient for a full work up. The lab came back inconclusive for HIV, so hospitalist #2 ordered further testing. When her symptoms resolved, the patient was discharged by hospitalist #3 with recommendation for follow up with a PCP and a psychiatrist. There was no discussion about follow up for pending HIV lab. The day after discharge, the HIV test result came back positive and was documented in the medical record. No one notified the patient.

One year later, the patient was seen in an urgent care clinic for persistent cough. The patient had blood labs drawn which revealed that she was HIV positive.

ANALYSIS

What happened? Why wasn't a patient with a positive HIV test notified of the results? One may consider this to be a failure to diagnose or a delay in diagnosis. The more central issue was a lack of communication. Moreover, the Swiss Cheese Model applies and identifies multiple areas of failures:

1. The EDP did not follow up on her lab order;
2. The EDP and the hospitalist #1 did not communicate directly about the need for the HIV testing and follow-up;
3. The hospitalist #2 did not follow up on his lab order or communicate directly with hospitalist #3;
4. A positive HIV test result was not defined as a "critical result," nor did the hospital policy require that a positive HIV result be directly communicated to the ordering physician;
5. At discharge hospitalist #3 did not inform the patient to follow up on the pending lab; and,
6. The patient who was properly consented for the HIV test assumed that "no news is good news."

³Kripalani S, Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalist. *J Hosp Med.* 2007;2(5):31-323.

Risk Management Best Practices.

Hospitalist Risk Management⁴

Strong patient safety and risk management strategies are an important part of a hospitalist's practice and should include:

1. Hand-offs are crucial — Hand-offs necessarily involve communication and should be designed to assure the highest levels of continuity of care.

a. Patients with a PCP⁵ — The hand-off to/from the Primary Care Physician (PCP) should begin as soon as the hospitalist assumes care for the patient. Though the degree of involvement of the PCP with hospital care varies, the pre-existing relationship that the PCP has with the patient will help build trust with the patient and family.

b. Consult with the PCP — The PCP can provide valuable insights into sensitive issues like DNRs, surgical recommendations, and discharge plans.

c. Timeliness — Provide discharge instructions and follow up recommendations to the PCP, prior to discharge if possible.

d. Patients without a PCP — These patients are “on their own” at discharge and may require referrals and support that will assist them with obtaining follow-up care. Social workers, case managers, and others can assist, but there is no specific formula so a thorough patient assessment at discharge is essential.

e. Partner with the patient — The patient/family should be made aware of the treatment plan and understand what they must do.

2. Emergency Department Admissions — Hospitalists and the ED staff must work together to obtain as much patient information as possible. It is key to work together and establish agreed upon processes. For example, ED shift changes can be particularly problematic because the ED is undergoing its own hand-off process. Hand-off between ED physicians and hospitalists should be done before shift change, if at all possible.

3. Communication — Face-to-face communication between physicians is often difficult. Communication can be improved by implementing standardized communication modules such as SBAR.

4. Test Results — Establish a notification or process for follow-up of all ordered labs, imaging, pathology. The simple adage: “if you ordered it, you own it,” should be the rule of thumb.

5. Discharge — Develop pre-discharge protocol, discharge planning, structured patient education, written patient instructions and post-discharge follow up processes. Nearly half of discharged patients experience an error in medication continuity, diagnostic work up, or test follow-up⁶.

6. Follow Policies & Procedures — Be familiar with the hospital and system policies and procedures. Policies are evidence-based and designed to protect patients. They will form the framework for investigation in the event of an adverse outcome and/or claim.

Conclusion

Strong communication, hand-off, discharge and follow-up processes will reduce risk and liability. Utilizing the lessons learned and recommendations in this focused review can also contribute to patient safety and help prevent the adverse outcomes that lead to claims.

⁴The Hospitalist Manual, Manish Mehta and Arun Mathews, 2010, with specific reference to pages 193-202.

⁵The Hospitalist Manual; Pantilat et al., 1999; American Journal of Medicine, Goldman, Pantilat, and Whitcomb, 2001.

⁶Kripalani S, Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalist. J Hosp Med. 2007;2(5):31-323.

The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.

Tools and Resources:

The Society of Hospital Medicine
www.hospitalmedicine.org

The Hospitalist
www.hospitalmedicine.org

The Hospitalist Manual, Manisha Mehta and Arun Mathews, 2010

Cooperative of American Physicians
www.capphysicians.com

The Medical Board of California
www.mbc.ca.gov

Cooperative of American Physicians, Inc.

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