Tract: Hospitalist Model Innovations

Contact Details: Laith Bustani C/O QCH Hospitalist Group, 3045 Baseline Road, Ottawa, ON, Canada, K2H 8P4 Phone: 613-721-2000. Fax (613) 721-4785. laith@mdlib.com,

Title: The 2011 Inpatient Care Physicians Survey

Author: Bustani L, Maloney R, Coke W, Hacker P.

Background: [*Author's Note. This is a presentation of research in progress and intended to promote awareness and engagement amongst physicians attending the 2011 Canadian Hospitalist Conference.]*

Have attempts at promoting the concept of hospitalists been myopic?

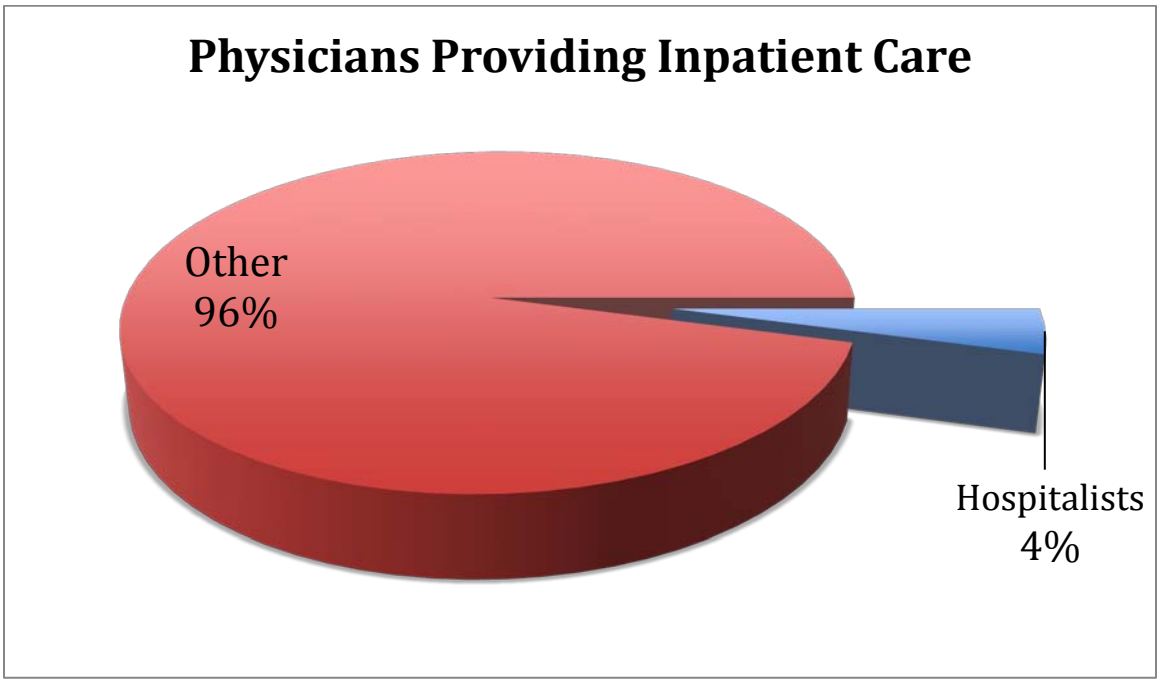


Figure 1: The aproximate proportion of physicians billing inpatient care codes in Ontario who self-identify themselves as hospitalists is only 4%, as based on primary or seconary membership in the section on hospitalist medicine and OHIP billing data.[1]

In 2006, the Ontario Physician Hospital Care Committee (PHCC) established the first of two successive Most Responsible Physician (MRP) Working Groups. These working groups were tasked with developing a conceptual framework for safe, efficient and sustainable MRP care. [2]

Individual Hospitalists and Hospitalist program leaders across the country were surveyed in 2007 to identify common issues and create a national data repository for future reference.[1]

Ontario-specific data was shared with MRP Working Group members. Though appreciative of the insights offered, the Working Group identified an inherent bias in the surveys methedology: only self-identified hospitalists were systematically surveyed while other groups of providers also providing MRP services were not (Figure 1). [1]

Though the MRP Working Groups made substantial progress, a definitive funding strategy for hospital-based care could not be secured and embedded in the 2008 Physician Services Agreement (PSA).[3]

A follow-up survey was conducted within Ontario in March of 2009[4], but was limited to MRP groups with only 26 responses obtained.

From 2009 onwards, considerable resources were invested by the Ontario Ministry of Health and Long Term Care (MOHLTC) to study the issues of Hospitalists and Inpatient care delivery. It organized second MRP Expert Panel, chaired by Dr. Robert Bell, consisting of members of the MOHLTC, Ontario Hospital Association (OHA), and Ontario Medical Association (OMA), including as a standing member, the chair of the OMA section on hospitalist medicine. The Minsitry employed the SECOR consulting group to help analyze data from inpatient care physicians through an Opt-in program that saw eligible MRPs able to bill a 30% premium on core inpatient care codes. To qualify, physicains had to consent to providing the entire spectrum of their billing patterns to the Ministry's third party analysts as a proxy of their clinical care activities. They also had to report (and reduce) their stipend payment from the hospital's operating budget by an amount equal to the premium codes.[5] The hope what that this data would be made available for analysis to the OMA, but due to a lack of a formal data sharing agreement only summary data was shared with the OMA members sitting on the MRP Expert Panel, and due to confidentiality agrements, communication/dissemination to the community of hospitalists was restricted.[6]

It is widely recognized that fee for service billings do not adequately capture the work performed by hospitalists.[1,2,3,4,5,7,7] and though site visits were performed and administrative and group surveys and expert consulations are being carried out, the voice of the individual physician providing inpatient care in Canada has been missing.

Methods:

The decision to resurect the individual physician and group survey was made at the 2011 OMA General Meeting of the Section on Hospitalist Medicine.

To addres criticism of the previous survey from the MOHLTC, the target audience was expanded to include all physician having provided inpatient care at any point in their career. As in 2007, both individual and group surveys were

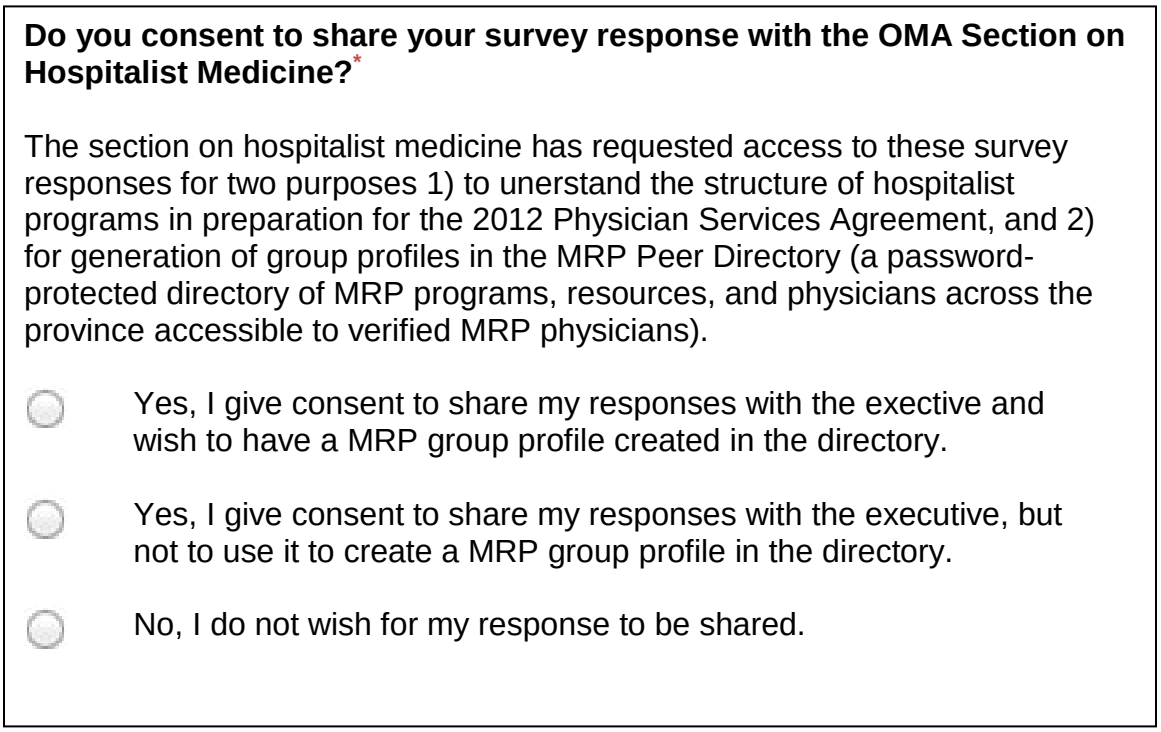
planned.

Existing surveys on hospitalist medicine from both the US and Canada were studied.[8]

For the individual survey, the various components and procedures of inpatient care were abstracted and organized in a manner that aspired to capture a complete and accurate profile of physicians variably engaged in providing MRP care, both within and outside of a formal group structure.

For the group survey, the OMA Secction on Hospitalist Medicien interpreted its mandate to include close collaboration in co-authoring the the group survey that was being launched by the MRP Expert Panel. A similar abstraction was included, to challenge the assumption that there is only one hospitalist group per hospital. Multiple "MRP Groups" are commonly observed to provide MRP service to discrete patient populations (e.g. acute medicine, geriatric, paediatric, psychiatry, ALC unit, rehab unit).

A formal opt-in data sharring agreement was secured with the MOHLTC (Figure 2).



Do you consent to share your survey response with the OMA Section on Hospitalist Medicine?*

The section on hospitalist medicine has requested access to these survey responses for two purposes 1) to unerstand the structure of hospitalist programs in preparation for the 2012 Physician Services Agreement, and 2) for generation of group profiles in the MRP Peer Directory (a password-protected directory of MRP programs, resources, and physicians across the province accessible to verified MRP physicians).

- Yes, I give consent to share my responses with the exective and wish to have a MRP group profile created in the directory.
- Yes, I give consent to share my responses with the executive, but not to use it to create a MRP group profile in the directory.
- No, I do not wish for my response to be shared.

Figure 2: This question was appended to the MRP Expert Panel's survey. A bilateral opt-in agreement became a means of "opening-up" the data collected by respective parties to broader analysis, while upholding the principles of informed consent and best practices for data collection.

Due to the limited scope of the group survey planned by the MRP Expert Panel

(only the lead physicains of groups already know to the ministry were surveyed), elements of the group survey were also included in the individual physicians survey to allow groups not on the Ministry's list to contribute their perspective.

The collaborative research and project management tools, created in honour of the original vision of a national data repository, were used to organize background material for the survey and promote continuous engagement in developing and refining the survey.[9]

The draft survey was circulated through the summer to the OMA Section on Hospitalist Medicine executive, the chairs of the section on general and family practice and the section of internal medicine. Deparmtmental chiefs in family and internal mediicne. Several volunteer physicians were recruited to complete the survey and provide additional feedback. The MOHLTC, OMA, and academic researchers were also consulted to review and advise on any perceived problems with the survey methodology.

As the survey was not dealing with confidential patient information, ethics approval was not obtained. Rather, it was emphasized that all questions (aside from those validating the physicain as a provider of inpatient care) were made optional with instructions to skip questions that did not seem relevant or appropriate.

Communication channels were cultivated with the section of General and Family Practice and Internal Medicine to promote the survey across their membership. Similar outreach is planned for the sections of Paediatrics, Psychiatry, and the Surgical Specialties.

Mechanisms to encourage viral distribution were engineered into the survey using social medial sharing tools (email, facebook, linkedin, twitter).

Incentives for lead hospitalists and administrators to organize campaigns to have their physicians from all their MRP groups complete the survey were included.

Based on feedback, a brief version of the survey was adapted from the original to provide an option to physicians only peripherally involved with inpatient care and might be overwhelmed by the scope of the full survey.

An introductory section communication (slated to be delivered via email September 21st 2011) was crafted, including a link to the online survey.

Results:

The survey launched Sep 21st in Ontario and will run through the end of 2011. Visit http://healthcollaborative.ca/inpatientcare/mrpsurvey to explore and /or participate in the survey.

The results of the data collected from the survey will be posted at this link following the conclusion of the 2012 Physician Services Agreement.

The raw data from the responses of consenting physicians will be made availble to qualifying physician researchers through an application to the Research and Development Working Group on mrpcollaborative.net.

Conclusions and Implications: This survey represents a significant conceptual shift. Rather than focusing on a specialized minority, an inclusive approach is taken where all physicians providing MRP care are represented. It remains to be seen whether this approach will yield new insights into how the hospitalist concept should evolve.

Three areas of criticism should be aknowledged.

The length and detail of the survey is considerable. Accordingly the brief survey option was created and the mechanics of the viral campaign re-engineered to encourage lead hospitalists to help coordinate the broad participation of physicians at their respective hospitals. This will hopefully reduce duplication while still providing adequate modeling of individual hospitals and groups that would otherwise go unrecognized.

There is concern of diluting the perspective and voice of small group of dedicated hospitalists relative to a large group of physicians who do not see themselves as such. This will be addressed through the used of subgroup analysis and is countered by a general faith that physicians are more alike in their attempts to provide the best care possible to their patients then they are different by virtue of their title or training.

Finally, the relative lack of resources to conduct this research and make full use of the collected data as well as its inherent short shelf life in a continuously shifting landscape suggests this may all be a fools errant. This, infact, highlights the central problem the mrpcollaborative.net platform[9] was designed to overcome. The survey, its questions, even the platform it is delivered on are governed by a creative commons share-and-share alike license. By providing the oportunity for ongoing engagement of physicians and cultivating a culture of open research and transparency, the accumulated body of knowledge becomes more relevant and valuable to the broader community, potentially sparking further research and inquiry by physicians who would otherwise not have the resources, logistical, or collegial support to translate their daily insight into transformative knowledge.

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Deepest gratitude to Arwa, Alya and Nora for their patience in enduring my ecentricities and focusing me with their love.

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[8] Reviewed Surveys Included: The 2009 MRP Expert Panels Site Visit Guide and Hospitalist MRP Funding Data Collection Template, the SHM Early Career Survey, The 2007 Canadian Individual and Group Surveys, the 2009 Ontario Group Survey.
[9] Details of this tool are described in a second poster by the author presented alongside the 2011 Inpatient Care Physicians Survey titled: mrpcollaborative.net : a social network and program management tool for MRP groups.