The Otolaryngology Hospitalist

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Financial Disclosure

- No commercial or grant funding for this project to disclose

Outline

- The Hospitalist Movement
- An Otolaryngology Hospitalist Model
- Return on Investment
What is a (Medicine) Hospitalist?

Old Models

- Community Practice
  - PCP → PCP

- Academic Medical Center
  - PCP → One-month/yr attending

New Model

- All Outpatient Providers
  - PCP → Hospitalists

Cause and Effect

- 1980’s- Managed Care
- 1990’s- Balanced Budget Act
- 2000’s- Resident Work Hours
- 2010’s- Health Care Reform Bill

Growth of the “hospitalists”

- IM hospitalists: fastest growing medical specialty
  - Within 15 years >30,000 Medicine Hospitalists
- Specialty Hospitalists
  - Pediatrics
  - Neurology
  - General Surgery (Acute Care Surgeons)
  - Ob/Gyn
  - Co-management

- All are essentially generalists who specialize in the care of acutely ill patients

When does a specialty hospitalist make sense?

1. Is the # of inpatients large enough to justify having a doc in-house during the days?
2. Is there a premium on urgent availability?
3. Are most of the specialists stuck in the office or OR when needed acutely?
4. Has the field become sub-sub-specialized?

Wachter, MSHRM, 2011
**What is an OtoHospitalist? (and why would you need one?)**


**UCSF**

Parnassus Heights
550 beds
45,000 ED/yr
22% admit rate

**Airway Liability**

- The loss of a difficult airway is rare, but the potential liability is significant
  - Nationwide airway lawsuits are increasing
  - $450,000 - ~$10 mil.
- JHU studied sentinel airway events (Tan, 2011)
  - 650-800 Code Blue/year
  - 10% with difficult airways and 1% needing emergent surgical airway
  - Reduced to zero sentinel events and 2 surgical airways with multidisciplinary difficult airway response team
  - Otolaryngology, Anesthesia/ICU, ED, Trauma Surgery
What is an OtoHospitalist?

- Other Duties:
  - Hospital Administration
  - Quality Improvement
  - Patient Safety Committees

The Otolaryngology Hospitalist: Pilot Program

- Consortium Model 2009-2011
  - Rotating weekly Faculty covering:
    - Inpatient Consultations
    - Emergency Department
    - Acute Care Clinic
    - Associated procedures and operative cases
  - Retrospective administrative database review
    - ICD-9
    - CPT

Demographics

- Inpatient consultations staffed by Faculty 2009-2011
  - N=375
  - Male 48%, Female 52%
  - Age (N=77)
    - Pediatric: 39%
      - 19.5% less than 1 year old
    - Adult: 61%

Service Breakdown
**Etiology**

- Infxn/Inflammatory: 35%
- Neoplasia: 7%
- Physiologic: 3%
- Iatrogenic: 4%
- Trauma: 4%
- Airway, Acquired: 21%
- Airway, Congenital: 26%
- Other: 11%

**Payer Mix**

- Contract 45%
  - Change/Collect: 0.45
- Capitation 7%
  - Change/Collect: 0.32
- Medicare/MediCal 44%
  - Charge/Collect: 0.176

- Inpatient providers are at a financial disadvantage
  - Consider a negotiated salary

**Q1 2011-2012**

- N= 155
  - Adult 112 (72%)
  - Pedi 43 (28%)
- OR Cases
  - N=51
  - Adult 27/Pedi 24
  - Does not include bedside procedures
- Extrapolating to a full year
  - N(est) = ~600

**Return on Investment**

The bottom line.
From the hospital point of view, a hospitalist is an investment

- Value = Quality/Cost
  - Improved Satisfaction
  - Decreased readmissions
  - Decreased length of stay
  - Decreased cost/patient

- IM hospitalists ($75,000)/FTE/yr
  - BUT, generate an estimated $425,000
  - Net positive for the hospital

- Surgeons increase revenue with RVUs but cost more
  - We will need to define our own Value equation

Return on Investment

- Operational Effectiveness
  - Annual billable encounters per FTE
  - Annual RVU/FTE
  - Process improvement

- Satisfaction
  - Patients, referring MD's, Nurses, ?Trainees

- QI/Patient Safety
  - Defining Metrics
  - Difficult Airway
    - Risk reduction

Summary

- The hospitalist movement is currently the fastest growing area of medicine in the US
- Hospitalists are generalists who specialize in the specific needs of acutely ill and medically complicated patients
- There is enough interesting Otolaryngology- surgical and non-surgical- to keep the right person interested
- A hospitalist decreases the headache and increases the productivity of the other members of the department

Conclusions

- The Otolaryngology Hospitalist is a viable practice model
- But… support will be contingent on demonstrating a positive return on investment.
- We must document and study our experience to demonstrate need for continued support.
Thank You

UCSF OHNS
Andrew Murr, MD
David Eisele, MD
The faculty and residents!

UCSF
Josh Adler, MD
Adrienne Green, MD
Bob Wachter, MD
The Division of Hospital Medicine