

# Virtual Mentor

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## MEDICAL EDUCATION

### Accounting to the Public through Focused-Practice Certification

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Efficiency and cost were the initial drivers of the hospitalist movement. Having physicians dedicated to managing the care of hospitalized patients minimized fragmentation of the primary care physician's work day formerly caused by frequent trips from the clinic to the hospital and back again. By being accessible to their patients throughout the day (i.e., unfettered by clinic obligations), hospitalists could make discharge decisions earlier, which reduced length of stay and increased hospital throughput. It was presumed that the concentrated focus on tasks that were performed repeatedly would improve efficiency, as it had done in emergency and critical-care medicine. Efficiency and the increasing complexity of inpatient medical care became compelling arguments for the hospitalist model.

#### Transitions of Care

As hospital medicine has evolved, the measurement of the hospitalist's value shifted from the narrow focus on efficiency during hospitalization toward the overall efficiency and quality of patient care from the ambulatory arena to the hospital and back again. A system that enables hospitalists to establish good communication with the primary care physicians during these transitions is best for both domains of expertise—efficient, accessible, and competent inpatient care that remains patient-centered and in-synch with outpatient care following hospitalization. This team-based approach has been the measure of quality for successful hospitalist programs.

#### Patient Safety and Systems Improvements

The next step in the hospitalist evolution followed the Institute of Medicine's (IOM's) 2000 publication, *To Err Is Human* [1]. The report noted staggering statistics on medical errors and brought the importance of patient safety to the forefront. The IOM suggested that many medical errors were not physician-dependent but were errors in the health care delivery system. This finding has been confirmed in later publications such as *Crossing the Quality Chasm* [2] and *Understanding Patient Safety* [3].

The established link between patient safety and patient care systems gave a boost to the hospitalist movement. Hospitalists become intimately familiar with their work systems, far more so than do visiting primary care physicians, and they develop personal relationships with all members of the health care team. It seems natural that, by practicing in the same venue day-in and day-out, hospitalists would be able to improve the efficiency, quality, and safety of care delivery. A review of literature in the past 5 years reflects this shift in focus: fewer studies now emphasize the cost

savings of hospitalists; more highlight hospitalists' work in improving quality and patient safety through systems analysis and change.

### **Board Certification and Public Accountability**

Like all physicians, hospitalists are accountable to society, particularly when it comes to ensuring safe, high-quality care during patients' transition from the ambulatory clinic to the hospital and while hospitalized. The question is how will hospitalists demonstrate objective competence in the critical elements of their practice—transition of care and systems improvement—upon which success of the hospital medicine model depends?

For more than 70 years, the internist's accountability to society has been facilitated by the work of the American Board of Internal Medicine (ABIM). The board certification process establishes that physicians who claim to be competent in their field have, in fact, demonstrated this competence. Recognizing that skills and knowledge fade over time, and that medicine is a constantly changing field, the ABIM improved this accountability by enacting the maintenance of certification (MOC) process. Internists must now demonstrate ongoing competence through a secure examination, self-assessment modules, and practice-improvement module every 10 years [4].

The certification process examines the competency of physicians who have been through a training program in their area of specialization. Those in hospital medicine recognize that it is not through training, but through practice, that the skills for competent hospitalists are developed. The current MOC process does not provide a mechanism for tracking competency of a non-training-based specialty.

ABIM is exploring a new initiative to recognize areas of "focused practice" through its MOC program in internal medicine. Here, focused practice recognizes areas within internal medicine where those maintaining certification can demonstrate proficiency. Hospital medicine is the first to be considered for focused-practice recognition; over time, ABIM will consider other areas that meet its criteria.

The focused-practice concept is currently being considered by the American Board of Medical Specialties, which oversees the certification processes of its 24 member boards. Meanwhile, the construction of the focused-practice certification program in hospital medicine has already begun, based on the dual tenets that physicians must (1) demonstrate competence as internists, and (2) have practice experience in hospital medicine. To become certified, hospitalists will have to complete specific performance-assessment requirements and take an exam in hospital medicine, with content similar to that of the current internal medicine examination but with a larger percentage of questions on inpatient care.

To successfully meet its public accountability goals, the MOC process must address two critical elements of a hospitalist's practice: transitions of care and systems improvements. To this end, the exam will address ambulatory-based content needed

for successful transitions of care. The inpatient-based content will assess the skills necessary for the primary management of inpatient medical disease, emphasizing consultation and co-management; responsible resource utilization; and the skills necessary to effect systems improvements to further patient safety and quality.

Some have questioned the motives behind recognition of focused practice in hospital medicine, arguing that it is a scheme to increase hospitalists' compensation. While this may be a result of the recognition, successful completion of the focused-practice requirement provides an objective means for guaranteeing that hospitalists possess the skills and knowledge necessary for quality care and patient safety in the hospital setting.

Critics of hospital medicine note that patient safety and quality of care are equally important in ambulatory medicine—a point about which there is no disagreement. But meaningful assessment of proficiency in systems improvements is best conducted in the venue in which the physician practices, and inpatient and outpatient clinical care venues differ significantly. For example, systems improvements to prevent deep-vein thrombosis, central-line infections, and ventilator-associated pneumonia are critical for the hospital medicine internist but less important for the predominantly ambulatory-based physician. Ideally, there would be a similar requirement for focused practice in ambulatory medicine, with equivalent attention to systems unique to the ambulatory settings. Perhaps as the patient-centered medical-home concept evolves, an ambulatory-care focused-practice requirement will emerge to test competence in the system skills critical to this care environment. In fact, objective certification might just demonstrate the physician accountability necessary to leverage funding the medical-home initiative.

Rudolf Virchow concluded his treatise on the typhus epidemic in 1848 by saying, “Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time” [5]. Hospitalists are not guilty for the magnitude of system-induced medical errors, but we are responsible. Will focused practice in hospital medicine solve our patient-safety and transitions-of-care problems? The answer is “no.” But there is no doubt that a program of focused practice in hospital medicine that emphasizing these skills—both through exams and self assessments of knowledge and practice—will eventually differentiate those who wish to be *perceived* as advocates of patient safety and quality *are those who are*.

We must be accountable to society in developing safe and effective health care systems. A program of focused practice in hospital medicine that objectively demonstrates competence in these principles is the first step to re-establish our covenant with society—one that promises that eventually, we will close the quality chasm.

## References

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