FAMILY MEDICINE AND HOSPITAL CARE

CHRIS HUGHES

OBJECTIVES

- EXPLORE DIFFERENT HOSPITAL CARE MODELS
- IDENTIFY CHALLENGES WITH HOSPITAL CARE IN RURAL SETTINGS
- IDENTIFY FAMILY PRACTIONERS ROLE IN HOSPITAL CARE

HISTORY

- THE LONE PRACTIONER
  - HISTORICALLY GP WAS TRAINED MORE BY APPRENTICESHIP AND ON THE FLY
  - MEDICAL CARE VARIED DRASTICALLY
  - FLEXNER REPORT
    - MORE STANDARDIZATION TO MEDICINE, MEDICAL EDUCATION
- LATE 1800S SHIFT TO CITIES AND HOSPITALS
- 1900S BECOMING MORE ORGANIZED AND REGULATED
- BULK OF CARE IN COMMUNITY

HISTORY

- FOLLOWING WWII, MORE SPECIALTIES AROSE
  - GERMANY AND ENGLAND MORE CUTTING EDGE
- 1960S
  - FRAGMENTED CARE, HIGH COSTS, DEPERSONALIZATION
- 1969 FAMILY MEDICINE BORN

HISTORY

- 1990S SHIFT TO HOSPITALIST MODEL
  - DECREASE LENGTH OF STAY AND DECREASED COSTS
- PROS
  - GREATER ACCESS TO OUTPATIENT PROVIDERS
  - AVAILABILITY
  - KNOWLEDGE OF “SYSTEM”
  - COSTS
- CONS
  - LOSS OF RELATIONSHIP
  - CONTINUITY/SHIFTWORK
  - WORKFORCE

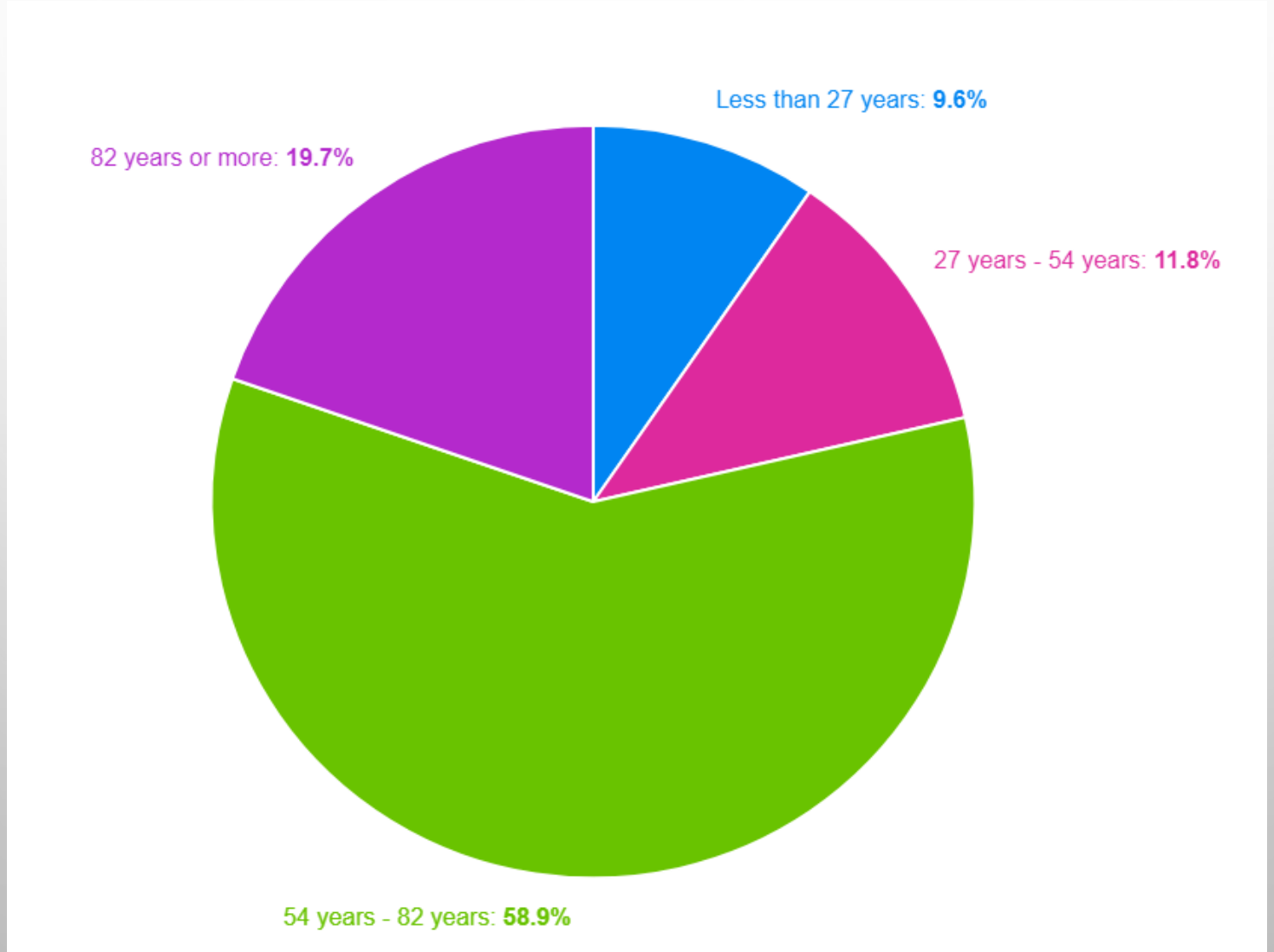
SO ALL OR NONE?

- CAN EVERYONE FIT THIS MODEL?
  - SOME HOSPITALS LACK THE WORKFORCE
  - SOME PROVIDERS STILL WANT BROAD TRAINING/WORK
- OB AND PEDS COVERAGE?
  - STILL RELY ON POTENTIAL FPS FOR PEDS HOSPITALIST
  - ARE OB/GYN SPECIALISTS AVAILABLE
- NPS AND PAS
  - HOW CAN THEY FIT INTO THIS SYSTEM

RIVERWOOD HEALTHCARE

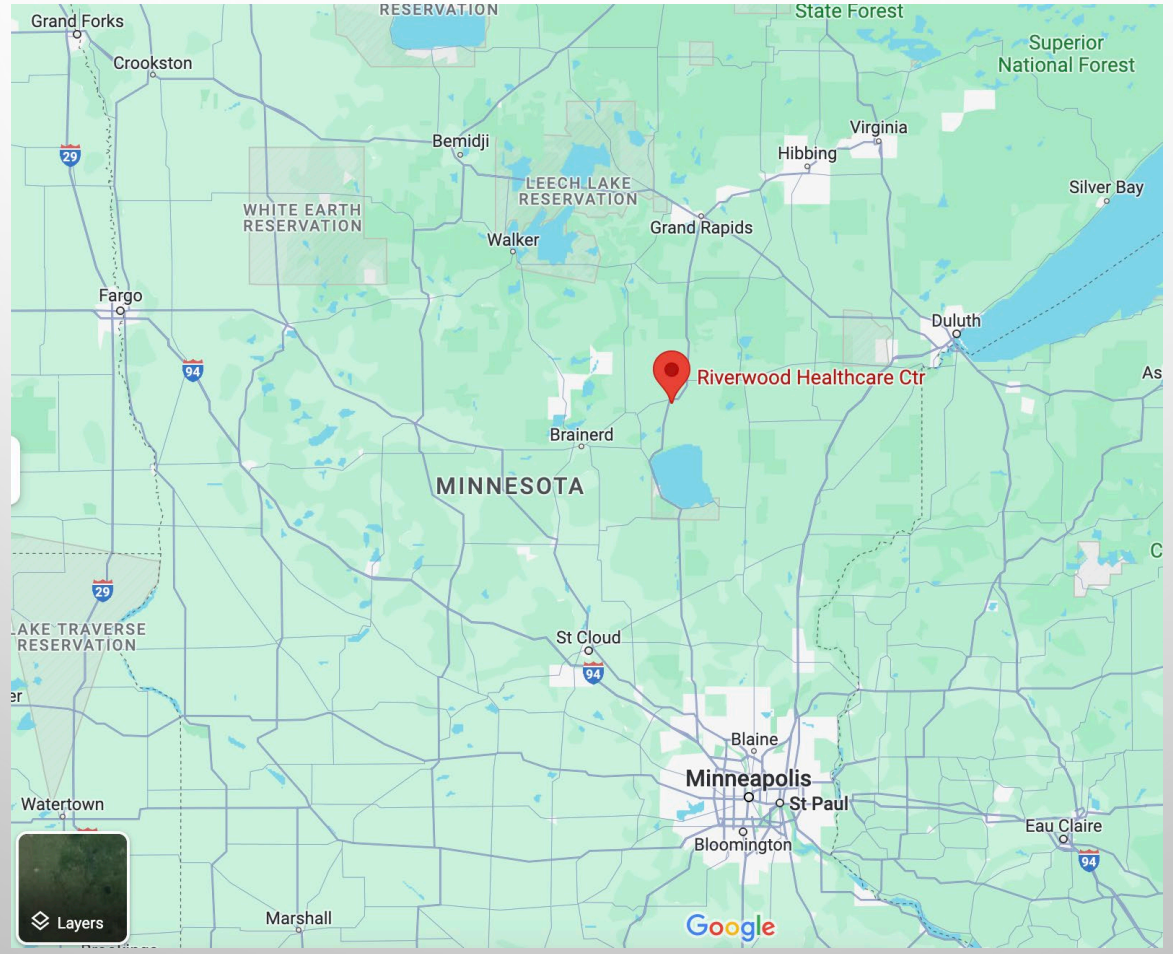
- 25 BED CRITICAL ACCESS
  - 3 ICU BEDS
  - ADDITIONAL 3 OB SUITES
- AVG. DAILY CENSUS IS 12 PATIENTS
- SPECIALTIES WITH ORTHO, GENERAL SURGERY, UROLOGY, OB/GYN
- ABOUT 400 INPATIENT SURGERIES PER YEAR

RIVERWOOD HEALTHCARE



RIVERWOOD HEALTHCARE

Transfer Centers
- -Duluth (86 miles)
- -St. Cloud (91 miles)
- -Twin Cities (126 miles)



OUR PROVIDERS

- 4 INTERNAL MED
  - 2 MDS AND 1 PA
  - 1 NP NOCTURNIST
- 7 FAMILY MED
  - 5 FULL TIME AND 2 PART TIME FAMILY MED MDS
  - RECENTLY LOST 2 FULL TIME PARTNERS (WERE 9 TOTAL BEFORE)
    - WITH LOSING PROVIDERS, MOVED TO TELEHEALTH COVERAGE

RIVERWOOD HEALTHCARE

- HOSPITALIST MODEL
  - 7AM-4PM DAY SHIFT, 4PM-7AM NIGHT SHIFT
    - 2 PROVIDERS FOR DAYSHIFT
    - ONE PROVIDER, NIGHTSHIFT EITHER NP OR TELEHEALTH
  - WEEKEND ROUNDING WITH TELEHEALTH ADMISSIONS
  - HAVE SHIFTED TO VIRTUAL NOCTURNIST COVERAGE WITH HORIZON TELEHEALTH
    - OTHER COMMUNITIES AS WELL (MORA, GRAND MARAIS, ETC.)

OTHER MODELS

- SOME AREAS ONLY EMPLOYEE A PURE HOSPITALIST W/O ANY OUTPATIENT PRACTICE
  - NPS/PAS SERVING BIGGER ROLE IN HOSPITAL CARE (GROWING NUMBER)
- OLDER SYSTEM OF ADMITTING AND FOLLOWING YOUR OWN PANEL IN THE HOSPITAL
  - LOWER VOLUMES, LESS ACUITY

INPATIENT/OUTPATIENT/CALL

- CALL BURDEN
- REALIZATION OF WORK/LIFE BALANCE
- SAFETY
- PATIENT CENTERED CARE
- TELEHEALTH
  - CREATIVE SOLUTION
  - EASE CALL BURDEN

CHALLENGES WITH HOSPITAL CARE

- HOSPITAL KNOWLEDGE
- GAP BETWEEN CLINIC AND HOSPITAL WIDENING
- DIVISION OF KNOWLEDGE
- FAMILY PRACTICE NICHE

WHY IT MATTERS?

- RURAL HOSPITALS ARE CRITICAL ASPECT OF OUR HEALTHCARE AND COSTS
- COVID-19 DEMONSTRATED LACK OF HOSPITAL BEDS IN THE STATE
- HOW TO WE MOST EFFECTIVELY TREAT PATIENTS AND LOWER COSTS
- TREND TOWARDS LESS OUTPATIENT/INPATIENT PRACTICES

FINAL ANSWER

- IT DEPENDS..

HOSPITAL MEDICINE

- COMPLEX QUESTION
- MAJORITY ARE SHIFTING TOWARDS HOSPITALIST/SHIFT WORK MODEL
- HOSPITALIST COMPOSITION DEPENDS ON THE PRACTICE
- TELEHEALTH EVOLVING ASPECT

QUESTIONS/DISCUSSION

WORKS CITED

- NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE; HEALTH AND MEDICINE DIVISION; BOARD ON HEALTH CARE SERVICES; COMMITTEE ON IMPLEMENTING HIGH-QUALITY PRIMARY CARE; ROBINSON SK, MEISNERE M, PHILLIPS RL JR., ET AL., EDITORS. IMPLEMENTING HIGH-QUALITY PRIMARY CARE: REBUILDING THE FOUNDATION OF HEALTH CARE. WASHINGTON (DC): NATIONAL ACADEMIES PRESS (US); 2021 MAY 4. 3, PRIMARY CARE IN THE UNITED STATES: A BRIEF HISTORY AND CURRENT TRENDS. AVAILABLE FROM: HTTPS://WWW.NCBI.NLM.NIH.GOV/BOOKS/NBK571806/

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