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Hospitalist Scope of Practice: Hospitalist Program

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Preamble:

The Fraser Health Authority has a Regional Hospitalist Department that currently serves eight acute care hospitals. The program provides inpatient serves including MRP, Consultations and some supportive care. The initial purpose of this service was to provide physician care to unattached medical patients who did not have a Family Physician. In the decade since its' inception, the FH Hospitalist Department has evolved into a service that provides most, if not all of the MRP responsibilities to the medical patients admitted to the eight sites. The general drift of physician specialist services to a predominantly consultative role has placed a considerable manpower and clinical scope of practice burden on the hospitalist service in FH. The reality of limited resources in health care delivery needs to be considered when the scope of practice of the FH hospitalist service is defined.

The expanded role of Hospitalists in FH has created challenges for Specialists, Emergency Physicians and Hospitalists when deciding on the disposition of admitted patients in the Emergency Room. The availability of physician manpower, the clinical skill set of physician groups, bed allocation decisions and variations in the perceived roles of various physician groups contribute to these challenges. Frequently the default disposition of Emergency Medical patients is to the Hospitalist physician. This may be appropriate, but should be a decision based on best practice and not a decision based on least resistance. It is for these reasons that a document outlining guiding principles of patient selection for the Hospitalist Service is essential to providing quality care to our patients.

The "Guiding Principles of Patient Selection" document is designed to simplify the disposition planning of patients who are being considered for admission to the Hospitalist service at any site in Fraser Health. The guiding principles do not attempt to identify specific disease states that are appropriate for the Hospitalist service. They guide the process of decision-making around disposition planning of all patients potentially earmarked for the Hospitalist service in Fraser Health.

In circumstances where Hospitalist manpower has been determined to be inadequate for the hospitals demand, prioritization of patients admitted to the Hospitalist service will be determined based on the clinical needs of the patient.

"Appendix A" provides disease specific examples of disposition decisions that are commonly required in Fraser Health for potential Hospitalist patients. This document does not define the scope of practice of Hospitalists in Fraser Health. It is provided to establish a middle ground of clinical problems that are managed by Hospitalists. Many sites provide a level of care identified

as "generally not appropriate for Hospitalists" on many of the diagnoses identified in Appendix A. The skill sets and physician resources at each site will ultimately determine the scope of hospitalist involvement. This will be determined eventually as each site looks at their particular setting. Appendix "A" merely gives a rough starting point from which to make site-specific plans. Having a starting point established by Appendix "A" keeps the focus of these discussions around a rough mainstream skillset. Ultimately this will be better defined as Hospitalists provincially and nationally define their core competencies.

"As with all guidelines in clinical medicine, these criteria should be used as a general guide rather than as definitive rules. Each case must be approached individually, and the expertise and experience of each clinician involved should be respected and taken into consideration."[1]

Guiding Principles of Patient Selection:

1. The Emergency Physician may make a request for the Hospitalist to admit to the Hospitalist service. The decision to *admit* a patient to the hospitalist service is the decision of the attending hospitalist. Patients shall remain the responsibility of the Emergency Department physicians until the patient has been accepted for *admission* to the hospitalist service.

2. Potential hospitalist MRP patients are those who are unattached to a family physician, Nurse Practitioner, or a specialist. The "attached" patient is one who has a family physician with admitting privileges to the facility or a specialist who is MRP.

3. Patients admitted in anticipation of surgery or whose primary diagnosis requires active management by a surgeon are **generally** not appropriate for admission to the hospitalist service. Patients who have received surgery shall remain under the care of the attending surgeon. Consultation with the hospitalist service may be sought and where appropriate, the hospitalist service may participate in the on-going management of the patient. If the patient is deemed stable from a surgical perspective (and is discharged from the surgical program) but still requires care for acute medical reasons, (not normal post operative care) then transfer the hospitalist service can be considered.

4. Patients for whom major diagnostic and therapeutic decisions will be made by a specialty service are most appropriate for admission to that service. Intrinsic to the decision to admit to the hospitalist service is the ability to add value to the care of the patient rather than simply implementing the decisions of another service.

5. Medically stable patients with an acute psychiatric episode should be admitted under the attending psychiatrist as MRP. Consultation with the hospitalist service may be sought for medical concerns, and where appropriate, the hospitalist service may participate in the on-going medical management of the patient.

6. Patients who are admitted into intensive care and/or specialized monitored care units (e.g. CCU, high intensity units) are not appropriate patients for the hospitalist service.

7. Until nationally accepted clinical (or other regional consensus-based) core competencies are developed, an attending hospitalist, in deciding whether to accept a patient to the Hospitalist Service, must consider 2 factors;

    1. Whether the presenting medical problem(s) can be adequately managed within the self-assessed competencies of the attending hospitalist, and
    2. Whether presenting medical problems can be adequately managed within the known or agreed upon competencies of the other hospitalists likely to be involved in the treatment of the patient.

    If both factors cannot be met, the attending hospitalist is, per College standards, professionally and ethically obligated to not accept the patient.

8. Where clinically appropriate, the hospitalist may participate in the ongoing care of a patient in a supportive role to a specialist. This may occur when a specialist is managing the daily care of the patient's admitting problem but there is a need to manage that patient's co-morbid disease because these problems falls outside the scope of the specialist's skills.

9. In situations in which the appropriate Specialty service is deemed by both responsible Program Medical Directors to have an insufficient number of Specialists to safely assume MRP roles at the Hospital, "co-management" (see Def'n) of the patient between a Specialist and Hospitalist, wherein the Hospitalist functions as the MRP, may be considered if the following conditions are met;

    a) a full consultation is completed by the Specialist,
    b) the level of ongoing Specialist involvement in diagnostic evaluation and treatment planning required by the Hospitalists can be provided, and
    c) the initial Hospitalist and the consulting Specialist mutually agree to the co-management.

10. Hospitalists do not do pre-operative assessments of patients for the preparation or the determination of fitness for the surgical procedure.

11. Patients may be transferred from the care of a specialty or intensive care service to the hospitalist service if the above principles (1 -10) can be met and the workload within the hospitalist service allows it. This decision is ultimately under the discretion of the hospitalist service based on the above principles.

[1]Appendix C: Hospitalist Scope of Practice: Calgary Regional Hospitalist Program

DEFINITIONS:

- **Most Responsible Physician (MRP)** – Means the medical staff member who, by direct admission or transfer of care, accepts primary responsibility and accountability for the care and treatment of a patient in a Fraser Health acute care facility. Use of the term Most Responsible Physician includes "or designate.*
- **Supportive Care** – This can take the form of "**Consultation only"** in which the physician is asked to make an assessment and management suggestions, or **"Consultation with Directive Care".** In the latter circumstance, the physician assists with the ongoing care of the patient including appropriate orders and follow-up. The consulting physician (including Hospitalists) is not the MRP.*
- **Consultation with Continuing Care (Transfer of Care)** – In this circumstance the consulting physician (including Hospitalist) takes over the entire care of the patient and becomes the MRP.*
- **Co-managed physician care** – Care provided by two physicians where one is declared as the MRP, and the second physician provides **"Consultation with Directive Care".**
- **Co-morbid disease** – the group of medical conditions of a patient other than the disease initially responsible for the admission.
- **Hospitalist service** – Refers to the organization of Hospitalist physicians at a particular site or regionally.
- **Attending Hospitalist** – Refers to an individual hospitalist on duty at a particular site.

*Fraser Health "Most Responsible Physician (Acute Care)" Policy; April 2007