ABIM Holds Off on Comprehensive Certification

BY ALICIA AULT
Associate Editor, Practice Trends

Directors of the American Board of Internal Medicine have decided to assess the competencies described in its draft comprehensive internist proposal before formalizing any maintenance of certification pathway.

The ABIM board of directors met in February to discuss comments on its proposed Recognition of Focused Practice in comprehensive internal medicine. If ABIM had proceeded, office-based internists who completed a maintenance of certification module could have said their practice was focused in "comprehensive care."

During a public comment period, ABIM received more than 280 formal responses—from physicians, insurers, patients, and groups including the American College of Physicians, according to Dr. Richard Baron, chair-elect of the ABIM board of directors.

"The board has never sought this kind of feedback before," he said. It is important for the public to know that "the actions we did take and didn't take were very much informed by what we heard from a variety of stakeholders," said Dr. Baron, a practicing internist in Philadelphia.

The feedback prompted the board to rethink its proposal. At its meeting, it elected "to commit to develop the tools to assess the competencies" articulated in the proposal, Dr. Baron said.

The board also voted to test those tools in the real world with partners such as the ACP and others who have been developing the patient-centered medical home, he said.

There's no set time line for developing the assessment tools and piloting them, but work has begun, he said. The ABIM's statement about the proposal is available at www.ccimreport.org.

The ACP believes the ABIM's process worked. The ABIM board "seemed to listen," said Dr. Joel Levine, chairman of the American College of Physicians board of regents, in an interview.

Comments on the proposal varied widely, Dr. Baron said. He added, "Responses were quite blunt and candid in many ways, and quite thoughtful and constructive in many ways." Those in favor of the proposal said they thought the comprehensive designation would, correctly, recognize core competencies, that it would provide a new model for primary care, that it could improve patient care, and that it could encourage educators to teach these skills to future internists.

Critics said that most internists already were demonstrating the competencies, and that acknowledging only some would lead to more fragmentation of the specialty. Others criticized ABIM for seemingly acting alone or for creating more hurdles for internists. Many suggested that adding new expectations without adding compensation would be unwise and might even discourage trainees from going into internal medicine.

ABIM still would like to find a way to recognize those competencies, Dr. Baron said. But no matter the pathway, it would always be voluntary.

"We are looking for opportunities to assist a future of internal medicine that's sustainable and professionally gratifying," he said. "There's a lot of pain out there right now in the practice world. It is no one on the board's desire to make that worse."

Hospitals Grapple With New Joint Commission Safety Goal

BY MARY ELLEN SCHNEIDER
New York Bureau

The Joint Commission's new 2008 patient safety goal of requiring a process to respond quickly to a deteriorating inpatient is being mistakenly interpreted at some hospitals as a mandate for "rapid response teams" or "medical emergency teams."

Further, at some organizations that already have rapid response teams, staff have expressed concerns they will need to redo their established systems.

Dr. Peter Angood, vice president and chief patient safety officer for the Joint Commission, said such presumptions are incorrect.

Hospitals are simply being asked to select a "suitable method" that allows staff members to directly request assistance from a specially trained individual or individuals when a patient's condition appears to be worsening, he said. The key is to focus on early recognition of a deteriorating patient and mobilization of resources and to document the success or failure of the system that is in place.

"This is not a goal that states there needs to be a rapid response team," Dr. Angood said.

Many institutions in the United States have implemented rapid response teams, and the data on their efficiency is generally good, but not every study has been positive, Dr. Angood said. As a result, officials at the Joint Commission wanted to move forward with a more basic approach with the goal of avoiding variation in response from day to day and from shift to shift.

Regardless of how hospitals choose to implement the Joint Commission goal, hospitalists are likely to play a significant role in accomplishing it, said Dr. Franklin Michota, director of academic affairs for the department of hospital medicine at the Cleveland Clinic.

Organizations that already have a hospitalist program are leaning toward the use of rapid response teams or medical emergency teams, because hospitalists can function as members of the team. Some hospitals without an adequate number of staff to have a team in place around the clock are considering starting hospitalist programs. Another strategy would be to form teams that do not include physicians, he said.

The Joint Commission requirement will not be without cost, Dr. Michota said, especially for those organizations that need to add staff. If no professional staff was there at 2 a.m. before, the hospital now needs to take on the cost of salary and benefits for more employees, he said.

When hospitalists aren't a part of a response team, they are likely to be central to developing the response plan, said Dr. Robert Wachter, chief of the division of hospital medicine at the University of California, San Francisco.

While the Joint Commission requirement might seem like a greater challenge for small hospitals, Brock Slabach, senior vice president for member services at the National Rural Health Association, disagrees. In many cases, smaller organizations can meet the Joint Commission's requirements in easier fashion than large, urban facilities can, because they are more nimble and can work faster with less bureaucracy.

Rapid response teams, for example, can be tailored to a hospital's resources by using staff from the emergency department to respond to a call, he said.

A number of hospitals have already made a commitment to establishing some type of rapid response teams. Establishing these teams is one of the strategies advocated as part of the Institute for Healthcare Improvement's 5 Million Lives Campaign, a national patient safety campaign.

Of the 3,800 hospitals enrolled in the 5 Million Lives Campaign as of January, about 2,700 have committed to using rapid response teams, according to IHI.

This idea is catching on, said Kathy Duncan, R.N., faculty for the 5 Million Lives Campaign.

The cost of implementing these types of teams varies, she said. About 75% of hospitals in the campaign have done this with zero increase in full-time employees, she said. For most staff involved, this is just an additional task. Investment is required for training team members, which can be costly at the outset, she said. Hospitals also need to invest time to educate the rest of the staff on when and how to call for assistance.

Ms. Duncan's advice for implementing whatever process hospitals choose to respond to the Joint Commission goal is to start by assessing what resources are available. Next, don't just jump into implementation, but take the time to test the process and figure out how people will request assistance, when to make that call, and who should respond.

"Start small with a pilot process," Ms. Duncan said.

Implementing a Response Plan

Because of the complexity of implementing a process to respond quickly to a deteriorating patient, officials at the Joint Commission are giving hospitals a year to develop and phase in their program.

By April 1, the first deadline, hospital leaders were required to assign responsibility for the oversight, coordination, and development of the goals and requirements. By July 1, there needs to be an implementation work plan in place that identifies the resources needed. By Oct. 1, pilot testing in one clinical area should be underway.

The Joint Commission is serious about organizations meeting these implementation milestones, Dr. Angood said. Hospitals that don't meet the quarterly deadlines will be docked points on their evaluation.

For 2009, hospitals will need to comply with the following six "implementation expectations" set out by the Joint Commission:

- ► Select an early recognition and response method suitable to the hospital's needs and resources.
- ► Develop criteria for how and when to request assistance to respond to a change in a patient's condition.
- ► Empower staff, patients, and/or families to request additional assistance if they have a concern.
- ► Provide formal education about response policies and practices for both those who might respond and those who might request assistance.
- ► Measure the utility and effectiveness of the interventions.
- ► Measure cardiopulmonary arrest rates, respiratory arrest rates, and mortality rates before and after implementation of the program.

Index of Advertisers