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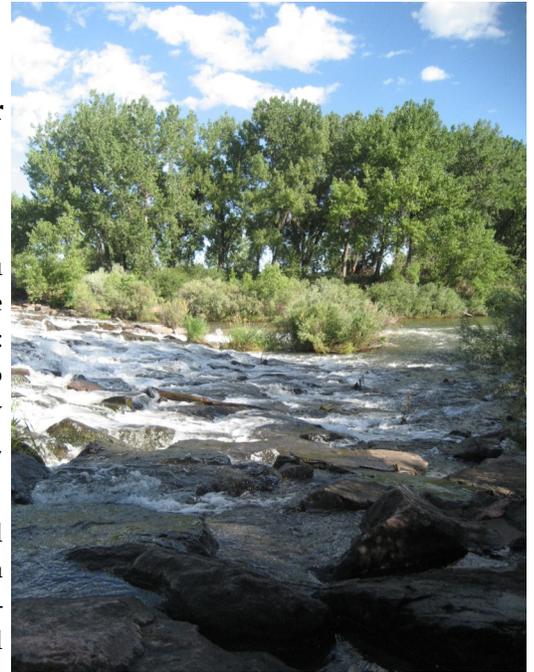
Why Does Team-based Care Matter to Hospitalists?

Les Hall MD

If at any point in my hospitalist career you asked me if I am a member of a health care team, I would have answered unequivocally: "Yes." However, if you then asked me who else serves on that health care team and how we are collectively participating in teamwork, I might have to pause and think a while.

Within our own hospitalist program, several changes have begun to tangibly reflect a commitment to interprofessional and interdisciplinary teamwork in recent years. Social workers and case managers now review pending discharges during the daily multidisciplinary rounds. Clinical pharmacists round with our inpatient teams, consulting on medication issues and identifying patient concerns with which they can assist. A recently added "morning huddle," between the physicians and nurses has been popular with both groups, ensuring that daily care goals are aligned early in the workday. Co-management of elderly patients with hip fractures, involving orthopedic surgeons and hospitalists, has become the new "norm" and both advanced practice nurses and physician assistants have been fully integrated into our care delivery process in a variety of settings.

We are not alone in promoting the value imparted by improving teamwork and communication among members of the health delivery team. Literature focusing on chronic disease management suggests that interprofessional teamwork improves outcomes and is valued by patients and providers [1,2]. Far less literature exists regarding the impact of teamwork in inpatient settings; however, we do know that breakdowns in communication among healthcare team members are the greatest contributors to the generation of serious adverse events in hospitals [3]. Common sense dictates that we need better strategies to improve communication and teamwork in the inpatient setting. The Joint Commission has built communication expectations (between providers and between providers and patients) into the National Patient Safety Goals [4] and the Institute of Healthcare Improvement is championing handoff tools and other means to improve communication between health care team members [5]. The Patient Protection and (continued)



(cont) Affordable Care Act of 2010 includes many incentives for health care organizations and providers to enhance team-based care.

In May, 2011, six health care professional organizations that make up the Interprofessional Education Collaborative issued a set of core competencies in interprofessional collaborative practice [6]. These establish a common platform of ethical understanding, knowledge of roles/responsibilities, communication practices and teamwork skills which should be shared by all health professionals. Even as this consensus on the importance of understanding and building upon teamwork skills emerges, many questions remain unanswered:

1. How do we include the patient and the family as true members of the care team in ways that add real value to the patient and lead to better outcomes?
2. Is teamwork essential to positive outcomes in all care settings (or only in select settings)?
3. How do we maintain professional identities (the positive differences between professions that allow each of us to make our unique contributions to patient care) as we try to meld into teams?
4. How does health professional education need to change to optimally prepare future caregivers for team-based healthcare? How important is interprofessional education?
5. How do we teach these skills to existing practitioners when they seem to be lacking?
6. How do we measure "teamness" in an individual or group? Do we know it when we see it or are there objective measurements of team-based skills?

So why does the team-based care emphasis matter to hospitalists? I believe that, in the years ahead, this issue will pose many opportunities for practice evolution, leadership within hospital systems and the creation of new knowledge. Hospitalists, who have in-depth knowledge of inpatient care delivery systems, are ideally positioned to partner with other health professionals to design, trial and refine new care delivery models in a variety of inpatient settings. Their engagement of other hospital leaders in this process can help to further solidify their roles as inpatient clinical leaders, the kind of leaders who gain respect and influence due to their expertise in collaboration rather than via the traditional power hierarchy of past health care systems. Lastly, as hospitalists use qualitative and quantitative techniques to measure the impact of these changes on patient and provider perceptions of care, patient safety events, cost of care and health outcomes, they will help to clarify the answers to the questions posed above. The immediate future should provide hospitalists many chances to partner with patients, other providers and health care leaders to develop more effective teams that improve patient care.

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CASE OF THE MONTH Bishnu Devkota MBBS, MHI, FRCS & Yashaswini Yeragunta MD

DELAYED PRESENTATION OF PRIMARY SPONTANEOUS PNEUMOTHORAX

ABSTRACT: Primary spontaneous pneumothorax occurs when there is an accumulation of air in the pleural space without a history of trauma or an underlying medical disorder. It is usually seen in young individuals with a history of tobacco use. The clinical presentation is most often acute with chest pain and/or dyspnea; however, some patients have a delayed presentation. We present a case of primary spontaneous pneumothorax with delayed presentation and discuss the management of this condition and issues related to the prevention of its recurrence. The role of the hospitalist in patient education is emphasized since counseling during hospitalization for an acute illness is the most effective means to discourage continued tobacco use.

CASE REPORT: A 35 year old Caucasian male presented with a three week history of shortness of breath; the onset was sudden, while working in his yard, and was accompanied by sharp, right-sided chest pain. While the pain subsided, the dyspnea gradually worsened and he sought medical attention. His medical history included depression, neonatal endocarditis and tobacco use for 20 years. Medications included lamictal, Paxil and Ambien. Exam was remarkable for a displaced PMI in the left 7th intercostal space at the anterior axillary line; the trachea was displaced to the left, percussion revealed hyperresonance over the right lung and decreased breath sounds were heard on the right side. A CXR revealed a large pneumothorax (see image on next page).

The patient was admitted to the hospital and a chest tube was inserted in the right 5th intercostal space; this tube was connected to a water seal drainage system. A followup film revealed resolution of the pneumothorax and the patient was discharged to home after counseling for smoking cessation. Another CXR, obtained in the Pulmonary Clinic two weeks later, was also normal, with no recurrence of the pneumothorax.

DISCUSSION: Pneumothorax is classified as spontaneous, traumatic or iatrogenic. Spontaneous pneumothorax may be primary (no underlying lung disease) or secondary (related to underlying lung disease).

Primary spontaneous pneumothorax (PSP) has an estimated incidence between 7.4 and 18 cases per 100,000 men and between 1.2 and 6 cases per 100,000 women. It typically occurs in tall, thin males between the ages of 10 and 30 and rarely occurs over the age of 40 [1,2]. Cigarette smoking increases the risk of PSP in men by a factor up to 20, in a dose-dependent manner [2]. Wakai reports that smoking increases the risk by a factor of 22 in men and 8 in women [3]. A study in Sweden showed that cigarette smoking increased the risk by a factor of 22 in men and 9 in women and demonstrated a striking, statistically significant ($p < 0.001$) dose-dependent relationship between tobacco use and the occurrence of PSP [4]. This study also reported that persons with a life-long history of heavy tobacco use have a 12% incidence of PSP vs an incidence of 1/1000 among those who have never smoked. In non-smokers, one should inquire about a family history of PSP; this is seen with Birt-Hogg-Dube syndrome, (cont)