‘RE-IMAGINING’ CARE DELIVERY:
PUSHING THE BOUNDARIES OF THE HOSPITALIST MODEL IN THE INPATIENT SETTING
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Providers are facing increasing pressure to “re-imagine” care delivery to dramatically improve value, quality and service. Commercial payers in many markets are moving more quickly than the federal government to institute contracts that shift greater risk for the costs and outcomes of care to providers. Reimbursement rates are also expected to remain flat or decline over the next several years. These changes will require providers to significantly reduce costs while also demonstrating better outcomes. Improving performance will require a level of coordination and efficiency across the continuum that has eluded many healthcare organizations. Despite rapid growth in ambulatory activity, inpatient care will remain one of the most expensive components of the healthcare system. Achieving higher levels of performance will require health systems to design new inpatient care delivery models that place the patient at the center of a team of providers coordinating care across the continuum. An effective, integrated hospitalist program is a central pillar of the care model of the future, promoting seamless transitions among providers and settings which improve efficiency and outcomes.

The Performance Plateau
The traditional hospitalist model has focused primarily on providing efficient inpatient care to the general medicine population. This model developed over the past 20 years as a result of four major drivers: 1) a shortage of primary care physicians in the community; 2) the opportunity cost of covering both the ambulatory and inpatient settings on a daily basis; 3) a shift in reimbursement mechanisms to case rate structures; and 4) reduced availability of resident staffing due to residency work rules requiring a cadre of staff physicians to care for patients. The success of the hospitalist model has been documented – most providers can demonstrate positive outcomes from their hospitalist programs, particularly reduced inpatient length of stay and resource utilization. Some high performing programs use hospitalists to optimize the triage, rounding and discharge processes to help alleviate bed crunches.
and more rapidly decant the emergency department and improve patient flow across the entire hospital.

Despite these improvements in the inpatient setting, performance in many organizations has plateaued, raising questions about how to achieve “next-level” performance by better integrating and leveraging existing hospitalist programs. The growing emphasis on documenting processes of care and outcomes is pushing providers to broaden the focus of hospitalist programs beyond LOS and efficiency to include readmission rates, core measures, and patient satisfaction. However, hospitalist programs are often designed without thinking about how to optimize transitions of care or communications with the physicians providing ambulatory or post-acute care. In addition, many hospitals are focused on achieving efficient staffing patterns and workload levels in order to improve hospitalist efficiency and productivity rather than developing mechanisms to improve outcomes.

Establishing a Platform of Excellence

Some providers are determining how to fully optimize and integrate their hospitalist programs to support a patient-centered, coordinated care delivery model. A hospitalist program that is embedded in the fabric of the organization and is fundamental to the overarching care delivery model across the continuum is core to this strategy. However, many hospitals organize the hospitalist program as distinct and separate from the other medical/surgical specialties and other parts of the hospital. For example, while hospitalists often demonstrate improved results for their patients, they are often relegated to specific patient care units and limited in their involvement with other parts of the organization. Optimizing the hospitalist program can only occur if the program is aligned with the organization’s overall goals and the hospitalists are fully incorporated into clinical and operational decision-making regarding how care is delivered across the continuum.

Health Partners Medical Group (HPMG) provides an example of an effective, fully-integrated hospitalist program contributing to new levels of outcomes performance. One of HPMG’s hospitalist practice sites is Regions Hospital in St. Paul, Minnesota. Regions Hospital is a Level I trauma center and tertiary care center and an academic affiliate of the University of Minnesota. HPMG partners hospitalists with other clinical and administrative leaders to design and implement innovative care delivery and operations approaches that have resulted in material improvements in quality, service and cost. HPMG focuses on developing strong relationships among the hospitalists, specialty physicians, nursing leadership and staff, and other members of the healthcare team. Hospitalists frequently work in dyad partnerships with other administrative or clinical leaders. The integration of physicians into leadership and day-to-day hospital operations is core to the Regions Hospital and HPMG culture. Over the past several years, Regions Hospital has seen material improvements in quality and patient satisfaction by leveraging this alignment, as indicated by the measures in the tables on page three.
While variations exist across successful programs, we have identified seven best practices of fully-integrated, high-performing hospitalist programs:

1. **Structured Recruitment and Selection Processes:** Many organizations have turned to hiring hospitalists in increasing numbers in order to ensure adequate coverage on inpatient services due to restricted resident work rules. Health systems frequently hire physicians directly out of residency programs with minimal experience as attending physicians. High-performing organizations are increasingly turning to structured recruitment and selection processes that ensure a proper fit and alignment with organizational goals, in part due to the variation in residency training programs and their graduates. Such selection criteria look closely at past experience during residency in improving quality, safety and patient experience. Additionally, new hires are exposed to on-boarding and orientation processes that emphasize adherence to standard processes and approaches to care, specifically with respect to rounding times, consistent use of evidence-based guidelines and clear definition and documentation of performance expectations. Furthermore, at HPMG, the belief is that no hospitalist should be only a teacher; this model requires teaching faculty to also carry a small census of non-teaching patients and dedicate a portion of their practice to non-teaching services. This requirement ensures that each faculty member maintains a commitment to clinical care and supports the hospitalist’s role as a steward of resources consumed in the delivery of care.

### Core Measure Performance Improvement

<table>
<thead>
<tr>
<th>Measure</th>
<th>% of patients meeting all of the required measures</th>
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<tbody>
<tr>
<td></td>
<td>2005 Full Year Result</td>
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<tr>
<td>Heart Attack Care</td>
<td>80%</td>
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<tr>
<td>Heart Failure Care</td>
<td>42%</td>
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<tr>
<td>Pneumonia Care</td>
<td>27%</td>
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</table>

### Patient Satisfaction Improvement

<table>
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<th>Hospital Survey Question</th>
<th>2008</th>
<th>2011</th>
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</thead>
<tbody>
<tr>
<td>% of patients indicating they would definitely recommend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regions Hospital</td>
<td>64.2%</td>
<td>76.6%</td>
</tr>
</tbody>
</table>

### Readmission Rate Improvement

<table>
<thead>
<tr>
<th>30-Day post discharge, non-elective readmission rate</th>
<th>2007</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>14.4%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>23.9%</td>
<td>19.2%</td>
</tr>
</tbody>
</table>
2. Geographic Deployment and Care Team Rounds: Providers should develop workflows that support building and maintaining relationships among the entire care team to encourage coordination. One mechanism that can be reinforced during the orientation process is collaboration and communication with other members of the care team in the form of face-to-face daily multidisciplinary rounds. Most organizations agree with the goal of daily multidisciplinary rounding; however, in practice they do not set appropriate expectations to achieve this objective. To be fully effective, these rounds must include the full care team – typically the hospitalist, unit nursing staff, pharmacist, case manager, social worker and when needed, chaplaincy and ancillary therapy staff – and must include an explicit scheduled daily meeting time to discuss issues from all team members. One challenge that can be addressed is the fragmentation of like populations across multiple patient care units. When attending physicians and residents are typically required to round on multiple units, it becomes much more difficult to support consistent processes or build relationships between the physicians and nursing staff. Organizations that cohort each physician’s patients, as a component of the patient placement process, are much more successful in supporting daily multidisciplinary rounds.

3. Nursing-Hospitalist Partnership: Organizations that link hospitalists to a particular unit are able to better support a team approach by partnering the nurses on the unit with a designated hospitalist whose role is to address issues or improvement topics with his or her hospitalist colleagues. HPMG has implemented a collaborative physician/nursing leadership structure for each hospital unit that pairs the hospitalist with the Unit Nurse Manager to support the care team. The Unit nursing staff participates in a “Unit Practice Council” where nurses and other staff voice issues that are then shared with the hospitalist with the expected outcome of increased communication and collaboration to benefit patient care. Another example of physician/nursing collaboration are Lean projects which are co-sponsored by the hospitalists, nursing leadership and hospital administration. As an example, one recent Lean project focused on improving communication and team work to reduce the number of pages, which in turn increased face-to-face communication opportunities in a busy hospital setting. Other projects focused on leveraging workflows, the electronic medical record and other tools to improve coordination, efficiency and staff and physician satisfaction with their practices.

4. Collaborative ED Triage and Direct Admission Efficiency: One improvement opportunity in most hospitals is the triage process for emergency department (ED) patients requiring admission to a hospitalist service, or consultation from the hospitalist before discharge from the ED to ensure the patient can be safely released with an ambulatory care plan. Processes that initiate post-ED care as early as possible for inpatients and observation patients, as well as transferring patients to the appropriate patient care unit, can significantly improve patient flow out of the ED. Organizations with high performing models have embedded the responsibility for triaging the patient to the appropriate service in the role of an attending or triage hospitalist to improve affordability and sustainability of the service. As part of the triage hospitalist’s daily routine, they round frequently in the ED to ensure timely access for consultation and coordination with patient placement to plan for bed need.
In teaching hospitals, introduction of a resident into the admission process adds complexity, which can result in delays in patient placement. To minimize this impact, triage hospitalists are generally on non-teaching services, in part to minimize the conflict that can arise when residents challenge admission decisions for ED patients. A single point-person who resides outside of the teaching model can more quickly assess and triage patients to inpatient services.

HPMG has implemented an effective process to streamline the intake process and improve customer service for the emergency department and outside referring hospitals. There is a designated hospitalist who takes calls for admissions, questions, consultations and patient transfers from outside facilities. The goal of this single call is to improve service to outside physicians and hospitals on behalf of the entire hospital. This service will accept patients 24/7, coordinating with other specialists as needed, thereby streamlining the intake service for outside referrers and reducing delays and diversions.

5. | Expanded off-shift coverage: Many 24/7 hospitalist practices and organizations currently limit the acuity of patients placed on non-teaching services with more complicated patients placed on teaching services. One reason for the acuity differential is the lack of in-house evening and night coverage for non-teaching patients. Nocturnists can play an important role in the coverage of both teaching and non-teaching services to ensure that optimal decision-making and treatment occurs during off-shifts. While nocturnists can increase overall labor costs, the focus on quality can minimize complications and delays in treatment that are likely to impact reimbursement moving forward. In an era of changing resident work rules and a renewed focus on quality, hospitalist programs must balance the acuity across teaching and non-teaching services. For non-teaching hospitals, the recruitment and retention of nocturnists increases the sustainability of the hospitalist practice by reducing the after-hours commitment in a hospitalist’s job description. Also, because nocturnists are assigned exclusively to cover the night shift, they are able to form relationships and develop consistent work practices and processes with the hospital’s other night workers, thereby improving flow, efficiency and satisfaction. The nocturnists have a unique role in a hospitalist practice and can help improve flow and clinical hand-over of the patient.

6. | Collaborative Relationship between Hospital Medicine and Palliative Care: Another area of opportunity for most providers is the level of collaboration between hospital medicine and palliative care. For patients and families facing end-of-life care, increased collaboration with palliative care can improve patient satisfaction and prevent or minimize hospital admissions and re-admissions for the last days of life. This collaboration must be supported by decision criteria on appropriate referrals to palliative care, as well as processes for joint rounding on patients and conducting patient/family conferences to outline the goals of care. At HPMG, the Palliative Care service is staffed by hospitalists who are board-certified in Palliative Medicine. This gives the practice a unique ability to blend staffing and talent to meet patient and family needs by providing patient-centered care.

Nocturnists have a unique role in a hospitalist practice and can help improve flow and clinical hand-over of the patient.
7. **Co-Management of Surgical and Behavioral Health Patients**: Though traditionally confined to the general medical patient population, organizations can begin to think about extending the hospitalist model to other areas. For example, using hospitalists to co-manage surgical and behavioral health patients may provide the greatest opportunity for providers to dramatically reshape inpatient care. Surgical inpatients are becoming increasingly complex as routine surgery continues to migrate to ambulatory settings, and the incidence of multiple co-morbidities rises. Analysis of inpatient discharge data from California suggests that 25% of all hospitalized patients can be considered “medically complex.” Furthermore, these patients account for approximately 75% of hospital acquired conditions. Surgical patients account for almost half of these cases and are not typically managed by hospitalists.\(^2\)

In a co-management model, a hospitalist could help improve post-surgical recovery of patients, while allowing surgeons to focus on pain management, DVT prophylaxis and other common post-surgical issues. Co-management could increase the surgeon’s time available for procedures, thus providing an opportunity for improved capacity utilization and revenue enhancement.

As part of the co-management model, hospitalists participate in and conduct pre-operative assessments of complex patients to ensure continuity when patients are transferred to the floor post-surgery. Hospitalists play a coordinating role in developing an assessment and order set template that is agreeable to primary care, anesthesia, surgery and hospital medicine. Additionally, hospitalists are incorporated into the organization’s quality program to improve Surgical Care Improvement Project (SCIP)\(^3\) measures and glucose control for the surgical population. HPMG has implemented an effective co-management approach across surgical specialties with hospitalists managing patients with complex medical needs by managing multiple medical co-morbidities, anticipating complications, and coordinating discharge medicines to achieve high levels of compliance and timely post-surgical recovery. The hospitalist team also coordinates the medicine discharge instructions and plan of care when post discharge care must be provided in a Transitional Care Center.

Similar to the surgical co-management model, hospitalists can work collaboratively with behavioral medicine. A hospitalist can focus on medical management of the patient, while the psychiatrist focuses on managing mental health. In HPMG’s experience, many patients admitted for mental health diagnoses many times have medical co-morbidities that have not been treated in the community, often contributing to the illness burden of this fragile population. The co-management model requires a high degree of collaboration and communication in order to ensure that all providers share a common understanding of the patient’s plan of care and work together seamlessly to implement the plan and ensure post discharge follow-up. Extension of the hospitalist model to these non-traditional areas can further minimize undesirable variation in treatment patterns and reduce complication rates.
Looking Forward

Many health systems are rethinking the fundamentals of today’s care delivery models and looking to innovative solutions to the challenges of demonstrating excellent outcomes while managing increasingly complex patients in an environment of constrained resources and finances. Providers must find a way to significantly reduce the cost of inpatient care while simultaneously improving quality across the continuum. Traditional models are unlikely to provide the solutions that are needed to remain competitive in the future. Building the inpatient care delivery model of the future around a strong hospitalist program that extends beyond the boundaries of the general medicine population and improves transitions across care settings can dramatically improve performance and provide a foundation that can be linked to other components of the continuum.

References


2. The Chartis Group analysis, CA hospital discharges 2007-2010. CA Office of Statewide Health Planning Department (OSHPD) patient level database.

3. The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations interested in improving surgical care by significantly reducing surgical complications. SCIP Partners include the Steering Committee of 10 national organizations who have pledged their commitment and full support for SCIP.