Capturing the Full Value of the Hospitalist Program

Imperatives for improving hospitalist program ROI

Look inside for:
- Strategies for expanding hospitalist program value
- Guidance for driving hospitalist program improvement
- Physician leader’s checklist for optimizing hospitalist role
Now that you’ve learned 13 imperatives for capturing the full value of the hospitalist program, use our Hospitalist Program Improvement Toolkit to implement change within your organization.

More in this membership

LEARN HOW TO

- Realign hospitalist program priorities to health system needs (p. 32)
- Refine clinical comanagement agreements to maximize hospitalist value (p. 45)
- Learn how to optimally deploy hospitalists in transitional care post-discharge (p. 97)

BEST FOR
Chief medical officers and hospitalist leaders

HOSPITALIST PROGRAM IMPROVEMENT TOOLKIT

- Hospitalist Program Gap Assessment
- Hospitalist Program Improvement Plan
- Meeting Guide: Optimizing Clinical Scope
- Hospitalist Role Red Flag Audit
- Hospitalist Financial Impact Estimator
- Quality Improvement Prioritization Grid

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READING TIME
90 min.

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WHAT'S NEXT?
Capturing the Full Value of the Hospitalist Program

Imperatives for improving hospitalist program ROI
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Available Within Your Physician Executive Council Membership

To support implementation of the strategies in this book, the Physician Executive Council (PEC) has created an online Hospitalist Program Improvement Toolkit. Several of these tools are highlighted here, and the comprehensive suite of resources, including webconferences, red flag audits, and research briefings, is available on advisory.com.

Additionally, physician leadership is a critical component of any successful hospitalist program. Physician leadership development is not addressed in depth in this publication, but is covered extensively in other PEC resources, shown here.

The Physician Executive Council also provides a variety of other resources that may be of interest to hospitalist leaders and practicing hospitalists, such as resources on palliative care and patient experience.

If you would like guidance navigating these resources and selecting those most relevant to your organization, please contact your Advisory Board relationship manager.

The Hospitalist Program Improvement Toolkit

- Contains tools designed to increase the ROI of your hospitalist program
- Available online at advisory.com/pec/hospitalisttoolkit
- Tools include:
  - Hospitalist Program Gap Assessment
    Benchmark your program against the attributes of high-performing programs
  - Special Report: Specialist-Hospitalists
    Details about an emergent model and how to assess your organizational need
  - Meeting Guide: Optimizing Clinical Scope
    Facilitate meetings that develop a thoughtful and rational hospitalist clinical scope
  - Hospitalist Financial Impact Estimator
    Tool translates quality improvement gains into potential financial impact

Physician Leadership Resources

- Building the Physician Leadership Team of the Future
  Observations and discussion guide on the evolving role of the physician leader

- The Clinical Transformation Leader's Toolkit
  Strategic and project management resources for leaders

- Physician Leadership Effectiveness Compendium
  Best practices for elevating physician leadership performance

Related Resources for the Hospitalist Team

- Realizing the Full Benefit of Palliative Care
  Service optimization and strategic growth

- Engaging Physicians in Patient Experience
  Tactics to engage physicians in patient experience initiatives

- Physician Communication Toolkit
  Resources for improving communications with physicians

To access these and other Physician Executive Council resources, please visit advisory.com/pec
Advisors to Our Work

The Physician Executive Council is grateful to the individuals and organizations that shared their insights, analysis, and time with us.

We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

With Sincere Appreciation

Advocate Health System
Chicago, Illinois
Denise Keefe, MBA
Christine Ricker

Ardent Health Services
Tulsa, Oklahoma
Donald Baker
Steven Landgarten, MD

AtlantiCare Regional Medical Center
Atlantic City, New Jersey
Anthony Macchiavelli, MD, FHM

Aurora St. Luke’s Medical Center
Milwaukee, Wisconsin
Eric Siegel, MD

Banner Health
Peoria, Arizona
Michael Reitz, DO

Baptist Memorial Health Care
Memphis, Tennessee
Mark Swanson, MD

Beth Israel Deaconess Medical Center
Boston, Massachusetts
Lauren Doctoroff, MD

Carilion Clinic
Roanoke, Virginia
Susan Lee, DO
Ralph Whatley, MD

Carolinas Hospitalist Group
Charlotte, North Carolina
Shannon Carpenter, MBA
Scott Rissmiller, MD

Carolinas Medical Center-NorthEast
Concord, North Carolina
Dan Hagler, MD

The Christ Hospital
Cincinnati, Ohio
Jeff Schlaudecker, MD

Christiana Care Health System
Newark, Delaware
Virginia Collier, MD
Robert Dressler, MD, MBA
LeRoi Hicks, MD, MPH

Community Medical Center
To ms River, New Jersey
Anthony Matejicka, DO

Cone Health
Greensboro, North Carolina
Robert Hickling, MHA

Cottage Health System
Santa Barbara, California
Edmund Wroblewski, MD

Good Samaritan Hospital
San Jose, California
Paul Beaupre, MD

Hospital Corporation of America
Nashville, Tennessee
Chris Frost, MD

Houston Methodist Hospital
Houston, Texas
Roland Cruickshank, MHA, MPA
Manasi Kekan, MD

IPC Healthcare, Inc.
North Hollywood, California
Jerry Wilborn, MD

Knox Community Hospital
Mount Vernon, Ohio
Jeffrey Northup, DO

Lahey Hospital & Medical Center
Burlington, Massachusetts
Chi Huang, MD

Lancaster General Health
Lancaster, Pennsylvania
Christopher Addis, MD
Lee Duke II, MD

The Longstreet Clinic
Gainesville, Georgia
Mimi Collins
Advisors to Our Work (cont.)

The Physician Executive Council is grateful to the individuals and organizations that shared their insights, analysis, and time with us.

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  *Boston, Massachusetts*  
  Jeffrey Greenwald, MD  
  Daniel Hunt, MD, FACP |
| **MedStar Georgetown Hospital**  
  *Washington, District of Columbia*  
  Steven Evans, MD |
| **Meriter Hospital**  
  *Madison, Wisconsin*  
  Jeremy Jaskunas, MD |
| **Middlesex Hospital**  
  *Middleton, Connecticut*  
  Rachel Lovins, MD |
| **Ministry St. Joseph’s Hospital**  
  *Marshfield, Wisconsin*  
  Peter Stamas, MD |
| **Montefiore Medical Center**  
  *Bronx, New York*  
  William Southern, MD |
| **Morton Plant Hospital**  
  *Clearwater, Florida*  
  Jordan Messler, MD |
| **Mount Sinai Health System**  
  *New York, New York*  
  Harry Cho, MD  
  Andrew Dunn, MD, MPH |
| **MUSC Health**  
  *Charleston, South Carolina*  
  Patrick Cawley, MD, MBA |
| **Newton Medical Center**  
  *Newton, New Jersey*  
  Paul Owens, MD  
  Kiranmayi Tadi, MD |
| **North Fulton Hospital**  
  *East Point, Georgia*  
  Karim Godamunne, MD |
| **Overlake Hospital Medical Center**  
  *Bellevue, Washington*  
  John Nelson, MD |
| **PeaceHealth St. Joseph Medical Center**  
  *Bellingham, Washington*  
  Kenneth Bachenberg, MD  
  Douglas Madsen, MD |
| **Pen Bay Medical Center**  
  *Rockport, Maine*  
  David Bachman, MD |
| **Providence Medical Group**  
  *Spokane, Washington*  
  Kirk Rowbotham, MD |
| **Sacred Heart Medical Center**  
  *Spokane, Washington*  
  Jeffery Liles, MD  
  Rebecca Mallo, MD  
  Carol Manix, RN  
  Richard Parker, MD |
| **Society of Hospital Medicine**  
  *Philadelphia, Pennsylvania*  
  Joe Miller, MS |
| **St. Francis Hospital and Medical Center**  
  *Hartford, Connecticut*  
  Surendra Khera, MD |
| **St. Tammany Parish Hospital**  
  *Covington, Louisiana*  
  Patrick Torcson, MD |
| **Sunrise Hospital and Medical Center**  
  *Las Vegas, Nevada*  
  Joanne Orlando, RN |
| **Virtua Memorial Hospital**  
  *Mount Holly, New Jersey*  
  Erik DeLue, MD |
# Capturing the Full Value of the Hospitalist Program

## Study in Eight Conclusions

1. **Hospitalist Programs an Underleveraged Strategic Asset for Hospitals**
   
   In most hospitals, hospitalists care for over 50% of patients. Additionally, hospitalist performance impacts many inpatient quality metrics that are now linked to pay. As a result, a high-performing hospitalist program is a key strategic asset, though few hospital leaders feel they have fully leveraged their hospitalist program to advance outcomes.

2. **Program Performance Often Defined Too Narrowly**
   
   Part of the problem is that executives are focused on a limited set of operational and productivity metrics that ignore the full potential of the hospitalist program. The investment required to operate a hospitalist program has grown over time, leading to increased financial scrutiny of the program. But while financial sustainability is critical, an over-focus here stifles the hospitalist program’s ability to contribute to broader organizational aims.

3. **Must Expand Definition of Hospitalist Program Value to Achieve Greater Returns**
   
   Hospital executives must think more broadly about how the hospitalist program can inflect quality and efficiency across the organization. This includes looking beyond traditional metrics, such as improved throughput, and considering the financial impact of improved performance on value-based purchasing metrics and savings from increased clinical standardization.

4. **Effective Hospitalist Alignment Requires More Than Aligned Incentives and Performance Metrics**
   
   Incentives increase focus on specific organizational priorities, but they don’t guarantee an ongoing commitment to overall organizational goals. To engage hospitalists as an organizational partner, hospital executives must work with hospitalist leaders to craft a shared vision of a high-performing program, and map the actions and resources required to realize the vision.

5. **Thoughtful and Rational Approach to Defining Hospitalist Clinical Scope Critical to Program Success**
   
   To maximize hospitalist productivity and value, clinical executives must consider the clinical needs of the organization, and where hospitalist support is most valuable. This often requires adjusting clinical comanagement agreements to specific patient populations and supporting the hospitalist team with dedicated AP and RN resources so hospitalists can consistently function at top of license.

6. **Hospitalist Program Well-Positioned but Often Unequipped to Lead Quality Improvement Initiatives**
   
   In many organizations, hospitalists are already participating in quality improvement initiatives, and are increasingly asked to take on a greater role. To prevent burnout and maximize hospitalist impact, executives must allow hospitalists to provide input into the quality improvement agenda, train hospitalists to become improvement leaders, and partner hospitalists directly with the quality improvement team.

7. **Progressive Programs Expanding Hospitalist Reach Beyond Acute Care Setting**
   
   Hospitalists have traditionally focused on discharge planning to improve cross-continuum care, but few organizations have carved out a more robust hospitalist role in accountable care. Organizations that are bearing risk for the entire episode of care should consider connecting or deploying hospitalists to post-acute settings to ensure patients receive cost-effective, high quality care after discharge.

8. **Investing in Hospitalist Program Can Improve Broader Organizational Culture**
   
   Because hospitalists interact with not only the majority of hospital patients, but also many of the organization’s physicians, nurses, and ancillary staff, investments aimed at developing a high-performing hospitalist program can yield significant organizational returns.
A Scalable Force for Quality
Hospitalists Firmly Established in Hospital Organizations

Hospital medicine has quickly grown to become a firmly established physician presence in nearly all hospital organizations today.

In fact, just over a decade ago less than a third of hospitals used hospitalists, while nearly three-quarters use them today. Nearly all hospitals with two hundred beds or more rely on hospitalists to deliver some portion of inpatient care.

This rapid expansion of hospital medicine was initially fueled by the need for greater operational efficiency, but today, there is increased recognition that hospitalists can inflect many more outcomes.

Greater Numbers of Hospitals Using Hospitalists

Percentage of US Hospitals with Hospitalist Service

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>29%</td>
</tr>
<tr>
<td>2008</td>
<td>55%</td>
</tr>
<tr>
<td>2013</td>
<td>70%</td>
</tr>
</tbody>
</table>

95% of 200+ bed hospitals use hospitalists

Source: AHA Hospital Statistics; Physician Executive Council interviews and analysis.
As hospitalists have expanded their presence in the hospital, they have also become an inflection point for overall organizational quality.

In 2015, the Physician Executive Council surveyed its members to understand the proportion of patients cared for by the hospitalist team. The overwhelming majority of respondents said hospitalists care for over 50% of patients; in fact, the most common response was 70%–90%.

Consequently, hospitalists significantly impact Medicare’s value-based payment metrics. Physician Executive Council experts took a detailed look at the value-based purchasing program and found that hospitalist performance is linked to approximately 80% of the metrics used for 2016.

Because hospitalists care for such a large proportion of patients and their performance drives organizational quality performance, they are truly a “scalable force for quality.”

**Distribution of Responses to “Percent age of Inpatient Admissions Cared for by Hospitalists”**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50%</td>
<td>13</td>
</tr>
<tr>
<td>50%-70%</td>
<td>21</td>
</tr>
<tr>
<td>71%-90%</td>
<td>35</td>
</tr>
<tr>
<td>&gt;90%</td>
<td>5</td>
</tr>
</tbody>
</table>

Most hospitalist programs care for 50% or more of inpatient admissions.

**Percentage of 2016 VBP1 Metrics Connected to Hospitalist Performance**

n=25 Measures Across Four Domains

80%
Because hospitalists are such a strategic lever for quality, it’s not surprising executives surveyed strongly agreed with the statement, “Having a high-performing hospitalist program is critical to organizational success.”

But only about a third of executives reported feeling confident that they had a high-performing hospitalist program.

This begs the question—why are hospital executives less than confident in their hospitalist programs?

**Program Seen as Vital, but Not Necessarily Strong**

**Everyone Agrees a High-Performing Hospitalist Program Is Critical…**

*Executives Who Strongly Agree That a High-Performing Hospitalist Program Is Critical for Organizational Success*

n=67 CMOs and Hospitalist Leaders

88%

**…But Not Sure They Have a High-Performing Hospitalist Program**

*Executives Who Strongly Agree That Their Organization’s Hospitalist Program Is High Performing*

n=71 CMOs and Hospitalist Leaders

32%

Source: Physician Executive Council April 2015 Hospitalist Program Survey; Physician Executive Council interviews and analysis.
One reason hospital executives are unsure about the performance of their program is because they are not fully considering the value hospitalists provide. Executives may over-rely on a narrow assessment of performance based exclusively on financial and operational metrics.

Almost all hospital medicine groups receive some sort of financial subsidy to cover their operating loss, and that subsidy is increasing over time.

The most common form of financial subsidy for hospital-employed hospitalist groups is the absorption of practice operating losses. For these groups, hospital organizations are not proactively investing in their hospitalist program—they are writing a check for the loss.

As a result, hospital executives are often focused on minimizing the loss—asking hospitalists to do more with less with the primary (and ultimately, narrow) goal of improving operational efficiency.

Executives are missing a bigger opportunity to position their hospitalists to lead broad, transformational quality improvement efforts. Organizations cannot ignore operational and financial performance, but a limited focus is causing them to miss out on a broader set of benefits.
The operational impact of hospitalist programs, including the benefits of improved throughput, coding and documentation, provide significant value to organizations today. However, their contributions to organizational performance can be much greater.

With the right support and expectations, hospitalists can have a profound impact on quality and culture across the organization.

For example, quality improvement initiatives led by hospitalists can lead to significant improvements in value based purchasing metrics and their associated penalties and rewards. Hospitalists can also have a major impact on overall cost per case and resource utilization.

Because hospitalists interact with so many clinical and non-clinical staff on a daily basis, they also have an outsized impact on culture. Their performance can drive satisfaction and engagement for members of the medical staff, and has also been associated with nursing satisfaction and retention.

Hospital executives must assess hospitalist performance through a broader lens, looking beyond financial and operational metrics, and accounting for their total impact on organizational performance.

---

**Programs Missing an Opportunity to Demonstrate Greater Value**

**Considering More Than Operational Impact from the Hospitalist Program**

**Developing Broader Hospitalist Program Value**

**Operational Impact**
- Throughput and efficiency
- Improved documentation and coding to reduce operating loss

**Quality Impact**
- Performance on value-based incentives (penalty avoidance, shared savings)
- Improved resource utilization and cost per case

**Cultural Impact**
- Improved clinician satisfaction and engagement
- Reduced employee turnover

---

Source: Physician Executive Council interviews and analysis.
Even if organizations recognize the broader value of the hospitalist program, realizing the full opportunity is no simple feat. There are many barriers hospitalist programs must overcome to optimize performance.

This graphic shows the four major, consistent challenges hospitalist programs must overcome to realize their full potential. The following pages outline these challenges in greater depth.

1. **Program Not Aligned with Hospital Priorities**
   - Fractured groups and disconnected stakeholders make hospital-hospitalist partnership difficult

2. **Hospitalists Stretched Too Thin**
   - Poorly defined roles limit hospitalist impact and yield diminishing returns

3. **Not Equipped for Quality Improvement**
   - Hospitalists unwilling or unable to successfully lead hospital quality improvement initiatives

4. **No Defined Role in Accountable Care**
   - Exclusive inpatient focus limits hospitalist ability to reduce costs across the episode

Source: Physician Executive Council interviews and analysis.
Regardless of employment model, hospitalists are often not fully aware or aligned with the priorities of the hospital. Financial incentives are not a panacea—even hospitalists with aligned incentives often do not fully engage in key hospital initiatives. For example, hospitalists may not prioritize the same challenges as hospital executives.

In addition, many hospitals have programs that are fractured. For these hospitals and health systems, the hospitalist program may include several competing hospitalist groups who are unable or unwilling to collaborate on shared goals.

**Representative CMO Concerns on Hospitalist Program Alignment**

“*Our hospitalists have aligned incentives, but they don’t prioritize goals the same way…they spend time on things we’re less concerned with.*”

“It’s hard for them to help us with what we need when they’re financially harmed for taking the time to help.”

“I’ve tried to get all the different hospitalists groups to work together for years…I’m ready to give up.”

“We need them to pull together and work for the system, not a single facility.”

“I can barely get all the hospitalist leaders to sit at the same table.”

*Source: Physician Executive Council interviews and analysis.*
Hospital executives, concerned about the cost of the program, are asking hospitalists to increase productivity even at the expense of quality. Many hospital leaders believe their hospitalist program is missing needed staffing and resources. Similarly, a quarter of the roughly 500 hospitalists surveyed in 2013 said their workload “often” or “very often” made them unable to fully discuss treatment options with patients and families, or answer their questions. Nearly the same number said it caused them to delay admitting or discharging patients in a timely fashion, and order potentially unnecessary tests or consultations.

This survey reveals the unintended consequences of increasing hospitalist workload without providing resources to maintain quality. While hospital executives might be pleased with the higher productivity metrics, they are paying for productivity with reduced patient satisfaction, greater resource utilization, and potentially higher readmission rates.

Non-clinical executive leaders may not fully appreciate this trade-off, making it difficult for physician executives to effectively advocate for necessary hospitalist program investment.

**Challenge #2: Hospitalists Stretched Too Thin**

**Trying to Do More With Less Is Not Working**

### Many Say Their Hospitalist Program Lacks Necessary Staffing, Support

**Many Programs Stretched Thin**

“The Hospitalist Program Has Adequate Staffing and Resources”

n=70 CMOs and Hospitalist Leaders

<table>
<thead>
<tr>
<th>Agree¹</th>
<th>Disagree²</th>
</tr>
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<tbody>
<tr>
<td>38%</td>
<td>62%</td>
</tr>
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</table>

### Diminishing Returns from Increasing Workload

Percentage of Hospitalists Who Say the Size of Their Workload Has “Often” or “Very Often” Caused Them to:

n=506 Hospitalists

- **Be unable to fully discuss treatment options or answer questions from patients and family members**: 25%
- **Delay admitting or discharging patients until the next shift or hospital day**: 22%
- **Order potentially unnecessary tests, procedures, consultations, or radiographs**: 22%
- **Increased the 30-day readmission rate**: 19%

---

1) Includes responses of “Tend to Agree,” “Agree,” and “Strongly Agree.”
2) Includes responses of “Tend to Disagree,” “Disagree,” and “Strongly Disagree.”
3) “Over the past year, how often has the number of patients you see or expected to see caused you to...”
4) “During the last year, how often do you think that your workload resulted in the following?”

Expanding hospitalists’ role to lead high-priority quality improvement initiatives is a common priority for many physician executives. In fact, nearly 70% of CMOs and hospital leaders said hospitalists are already developing and leading quality improvement initiatives.

However, working on quality has not necessarily translated to quality improvement. Two challenges typically stand in the way of execution. First, hospitalists may not know which initiatives to prioritize among an ever growing list. Second, hospitalists are often not equipped with the resources and support they need to produce measurable results.

### Challenge #3: Not Equipped for Quality Improvement

Quality Improvement a Top Priority, but Not Well-Resourced

**Hospitalist Programs Leading Quality Improvement Initiatives**

“The Hospitalist Program Is Developing and Leading Quality Improvement Initiatives”

n=70 CMOs and Hospitalist Leaders

- **Agree**: 69%
- **Disagree**: 31%

69% of respondents listed leveraging hospitalists for quality improvement as top strategic priority

---

1) Includes responses of “Tend to Disagree,” “Disagree,” and “Strongly Disagree.”
2) Includes responses of “Tend to Agree,” “Agree,” and “Strongly Agree.”
3) Percentage of respondents who ranked, “Leveraging hospitalists to lead high-priority system or facility quality improvement initiatives” as their #1 or #2 strategic priority.

Overload Causing Burnout

“The blizzard of new initiatives…thrust at busy clinicians has created overload. The problem…is that nobody freed up the time to do all this new stuff…Although many clinicians have been gratified by their work in safety and quality, I’m afraid this additional work has led to high levels of burnout.”

Robert M. Watcher, MD

“Is the Patient Safety Movement in Danger of Flickering Out?”

Hospitals are more accountable for performance across the episode, as the emphasis on outcomes and efficiency metrics has increased in Medicare’s value based purchasing program. However, hospitals are still not clear on the role hospitalists will play in this transformation.

Hospitalists can be a lever to improve quality and efficiency of care post-discharge, but few organizations have defined a clear role or expectations for hospitalists in this area.

Similarly, hospitalists often have an undefined or unclear role in the organization’s accountable care efforts. When it comes to risk-based arrangements, hospital leaders have mostly looked to other physicians for leadership.

There is an opportunity to involve hospitalists and define roles that coordinate care beyond the post-acute setting.

Not Including Hospitalists in Transition to Accountable Care

Medicare VBP¹ Program Domain Weights

<table>
<thead>
<tr>
<th></th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Outcomes of Care</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Process</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Not Connecting Hospitalists to Risk

46.7%
Hospitalists with no or unclear role in ACO

0%
Hospital executives who say population health is top hospitalist program priority

6%
Medicare revenue at risk from mandatory pay-for-performance programs², FY 2017

¹ Value-Based Purchasing
² Includes Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Conditions Program

Capturing the Full Value of the Hospitalist Program

To help physician leaders overcome these challenges, the Physician Executive Council has identified 13 imperatives to capture the full value of the hospitalist program.

- Chapter one focuses on how to improve alignment between different hospitalist groups, as well as alignment between hospitalists and the hospital or health system.
- Chapter two explores strategies for optimizing the clinical scope of hospitalists to focus on high-value, top of license support.
- Chapter three discusses the infrastructure and support hospitalists need to successfully implement quality improvement initiatives within the organization.
- Chapter four introduces potential roles for hospitalists in accountable care, with advice on how to choose a strategy that aligns with an organization’s current risk profile.

### Thirteen Imperatives for Improving Hospitalist Program ROI

#### 1. Realign Hospitalists with Hospital Priorities
1. Set minimum standards to reduce performance variability between hospitalist groups
2. Assess gaps between hospitalist program and hospital priorities to reset alignment
3. Position hospitalist leaders to maintain alignment

#### 2. Optimize Hospitalist Role
4. Refine medical comanagement model to maximize hospitalist impact
5. Evaluate opportunities to develop specialized roles for hospitalists
6. Ensure ROI from advanced practitioner hospitalist roles
7. Weigh dedicated RN support to increase hospitalist efficiency

#### 3. Position Hospitalists for Quality Improvement
8. Institute shared prioritization for QI initiatives
9. Equip hospitalists to lead quality improvement initiatives
10. Hardwire connectivity between hospitalists and quality department
11. Explore implementing unit-based models to increase hospitalist accountability

#### 4. Establish Role in Accountable Care
12. Establish hospitalist connectivity with strategically important SNFs
13. Consider deploying hospitalists to transitional care clinics

Source: Physician Executive Council interviews and analysis.
Realigning Hospitalists with Hospital Priorities

- Imperative 1: Set minimum standards to reduce performance variability between hospitalist groups
- Imperative 2: Assess gaps between hospitalist program and hospital priorities to reset alignment
- Imperative 3: Position hospitalist leaders to maintain alignment
Hospitalist groups are diverse in both employment model and their maturity, which makes building a single, cohesive hospitalist program difficult for many organizations.

For example, a hospital may rely on hospitalists from the local medical group as well as hospitalists from a nationally contracted staffing company. Arrangements like this are not uncommon—42% of surveyed hospital leaders told us they use more than one hospitalist group.

Hospitalists in the same hospital may have different incentives as a result. In some cases, the different groups may see each other as competitors rather than colleagues, making it difficult to establish a single, cohesive hospitalist program.

With so much variation between groups, hospitals are looking for a way to consolidate and standardize groups into a single, cohesive program.

Hospitalist Employment Model, Program Maturity Varies

**Percentage of Hospital Medicine Groups by Employment Model**

<table>
<thead>
<tr>
<th>Employment Model</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Medical Group</td>
<td>3%</td>
</tr>
<tr>
<td>Multi-State Hospitalist Management Company</td>
<td>10%</td>
</tr>
<tr>
<td>Hospital, Health System, or University</td>
<td>27%</td>
</tr>
<tr>
<td>Other</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years in Existence</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15+ Years</td>
<td>18%</td>
</tr>
<tr>
<td>10–14.9 Years</td>
<td>33%</td>
</tr>
<tr>
<td>5–9.9 Years</td>
<td>34%</td>
</tr>
<tr>
<td>1–4.9 Years</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Percentage of Hospitalist Programs with More Than One Hospitalist Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
</table>

42%

No Single Point of Leverage

“You can’t use them to spearhead change when they don’t recognize themselves as a single entity.”

Facility CMO with Multiple Hospitalist Groups

Hospitals and health systems increasingly view employment as a way to improve hospitalist alignment, but it doesn’t guarantee shared priorities.

Over the last decade, the percentage of hospitalists groups directly employed by a hospital or health system has grown to 50%.

Although employment can help reduce misaligned incentives, it doesn’t guarantee complete alignment between the hospitalist program and the hospital. To achieve meaningful alignment, they must still work together to develop a shared set of priorities and goals.

Employment of Hospitalists on the Rise

Percentage Hospitalist Groups Directly Employed by a Hospital or Health System

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>23%</td>
</tr>
<tr>
<td>2006</td>
<td>34%</td>
</tr>
<tr>
<td>2014</td>
<td>50%</td>
</tr>
</tbody>
</table>

“Employment Doesn’t Guarantee Aligned Priorities

“I have seen many organizations fail here…the objectives between hospital and hospitalist must be completely aligned. If one prioritizes patient satisfaction while the other prioritizes physician satisfaction, neither will achieve its goal.”

CEO and Former Hospitalist, Large Academic Medical Center

### Building a Foundation for Alignment

There are three common challenges health systems must overcome to build greater alignment with the hospitalist program:

First, to control for performance variation between hospitalist groups, hospitals must establish a minimum set of standards and performance criteria to eliminate or reduce extreme outliers that make building a cohesive group difficult.

Second, hospital executives and hospitalist leaders must bring together hospitalist stakeholders and form a shared view of gaps in the hospitalist program, and agree to a collaborative plan to improve it.

Finally, hospitalist leaders must be positioned to maintain alignment with hospital and health system priorities.

#### Three Common Challenges to Aligning Hospital and Hospitalist Priorities

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Imperative #1</th>
<th>Imperative #2</th>
<th>Imperative #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable performance between multiple hospitalist groups limits</td>
<td>Set minimum standards to reduce performance variability between hospitalist</td>
<td>Assess gaps between hospitalist program potential or the resources needed to</td>
<td>Position hospitalist leaders to maintain alignment</td>
</tr>
<tr>
<td>standardization and collaboration</td>
<td>groups</td>
<td>improve</td>
<td></td>
</tr>
<tr>
<td>No shared view of hospitalist program potential or the resources needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to improve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inconsistent connectivity and collaboration between hospitalists and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital executives</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Physician Executive Council interviews and analysis.
There are two types of hospitalist program variability—variability between different groups within a facility, and variability between programs across facilities operating within the system.

Both types of variability make it challenging to establish shared goals across groups. For example, a program trying to set a single target for readmissions would struggle to identify a goal that is motivating for low- and high-performing hospitalist groups.

**Imperative 1. Set minimum standards to reduce performance variability between hospitalist groups**

**Performance Variability Makes Goal-Setting Difficult**

**Hard to Align Multiple Hospitalist Groups to a Single Standard**

**Two Types of Hospitalist Program Variability**

1. Variation Across Multiple Hospitalist Groups Within a Facility
2. Variation Across Facilities Within a Health System

**Single Shared Goal Ineffective**

- Group B views target as impossible and ignores incentive
- Group A has no incentive to maintain strong performance

**Hospitalist Group Variability Common**

- **71%**
- Hospital leaders with more than one hospitalist group\(^1\) who say performance is highly or somewhat variable across groups

**Readmission Rate**

- **Group A**: 4%
- **Group B**: 18%
- **Group C**: 10%

**Target of 8%**

\(^1\) n=31, includes physician leaders, clinical leaders, and hospital executives; approximately 43% of all respondents said they have more than one hospitalist group operating in their facility or system.

Source: Physician Executive Council April 2015 Hospitalist Program Survey; Physician Executive Council interview and analysis.
To reduce variation across hospitalist groups within a single facility, begin by implementing a minimum standard that targets extreme performance outliers.

Houston Methodist Hospital found substantial variation among the 16 small, independent hospitalist groups serving the facility. With limited or—in many cases—no collaboration between groups, it was difficult to define a minimum quality standard.

The issue was raised to the Medical Executive Committee, which agreed to approve a certification requirement for all hospitalist groups to practice at the facility.

Houston Methodist then brought together physician leaders from each of the hospitalist groups to determine the minimum requirements for hospitalist group certification.

### Case in Brief: Houston Methodist Hospital

- 839-bed flagship hospital of seven-hospital Houston Methodist system based in Houston, Texas
- Approximately 45 hospitalists across 16 different hospital medicine groups saw ~50% of discharged patients; none had formal contracts with the hospital
- In 2013, VP of Operations and CQO convinced Medical Executive Committee to require hospitalists to be privileged and credentialed based on minimum group requirements
- Established Hospitalist Governance Council (HGC) to develop minimum requirements and goals; HGC enforces minimum standard and increases collaboration between groups
- After establishing standards, many independent hospitalist groups merged, dropping the total number of independent groups from 16 to six

Source: Houston Methodist Hospital, Houston, TX; Physician Executive Council interview and analysis.
Establishing Minimum Certification Criteria

The minimum certification criteria chosen by hospitalist leaders focused on standardizing the structural and management processes of each group, as opposed to setting a specific quality goal.

Focusing on structural variation allowed Houston Methodist to eliminate the underlying causes of variable performance. For example, solo-practitioners often could not meet minimum coverage criteria, which made length of stay more variable.

The criteria also set management process requirements, including the capability to review group metrics and discuss performance with other hospitalist leaders. Requiring more standardized processes made it possible to build a more cohesive program focused on similar goals.

Criteria Set by Hospitalist Group Leaders Reduces Variation

Houston Methodist Hospitalist Group Certification Criteria
(Excerpt)

<table>
<thead>
<tr>
<th>Group Size</th>
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</thead>
<tbody>
<tr>
<td>Minimum of five hospitalists per certified group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide 24/7 coverage with 30-minute in-hospital availability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round prior to 11:00 a.m. on patients anticipated to be discharged that day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in hospital’s quality incentive program that provides $30,000 quality bonus for success</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Leader Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducts monthly review of group metrics and overall performance</td>
</tr>
<tr>
<td>Represent group on Hospitalist Governance Council</td>
</tr>
</tbody>
</table>

Source: Houston Methodist Hospital, Houston, TX; Physician Executive Council interview and analysis.

Structural Certification Criteria
• Set minimum competencies and practice standards across groups
• Eliminate extreme performance outliers

Performance Certification Criteria
• Reduces variation between groups by putting pressure on lowest performers
The minimum bar established by the certification process ultimately reduced the number of distinct hospitalist groups, as many groups were forced to merge together in order to meet the new standards. The consolidation of groups established a more unified hospitalist team culture.

To work towards shared performance goals, the hospital and hospitalist leaders formed a hospitalist program governance structure. This structure unites leaders from each of the six groups, who meet on a regular basis to review hospitalist performance. Each group now participates in a quality incentive program that rewards them for strong performance.

While it is rare to have 16 distinct hospitalist groups practicing in a single facility, this case illustrates the opportunity to set minimum standards and build cohesion across competing groups.

**Certification Facilitates Consolidation and Alignment**

**Building a Common Hospitalist Program Culture at Houston Methodist**

**Hospitalist Groups at Houston Methodist**

<table>
<thead>
<tr>
<th>Before Certification Process</th>
<th>After Certification Process</th>
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</thead>
<tbody>
<tr>
<td>15</td>
<td>6</td>
</tr>
</tbody>
</table>

**Hospital Governance Council Reduced Fragmentation**

- Comprised of the leaders of all six certified hospitalist groups
- Monitors hospitalist groups to ensure they are meeting all certification criteria
- Meets monthly with hospital executives to review hospitalist performance metrics
- Leaders address underperformance with individual hospitalists as necessary

**On the Same Page**

This certification process has allowed us to establish a unified hospitalist program culture. All of the hospitalists are now working toward common goals.”

*Roland Cruickshank, VP of Operations  
Houston Methodist Hospital*
Another challenge is building a cohesive hospitalist program that spans an entire health system.

After a merger between Mount Sinai and Continuum Health Partners, the CMO implemented a system-wide quality dashboard. The dashboard identified significant cost and quality variation between sites.

The system CMO tasked the system-level hospitalist leader with reducing outcomes variability by creating a more standardized hospitalist program.

### System-Wide Quality Dashboard Identifies Quality Variation

#### Discharges per FTE Hospitalist

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>37</td>
<td></td>
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</tr>
</tbody>
</table>

#### Risk-Adjusted Readmissions Index

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1.41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>1.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>1.12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>1.05</td>
<td></td>
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</tbody>
</table>

### Case in Brief: Mount Sinai Health System

- Merger between Mount Sinai and Continuum Health Partners creates seven-hospital system based in New York, New York
- Five hospitals had own hospitalist programs; total of approximately 85 hospitalists across all sites
- System CMO adopts system-wide quality dashboard, asks system hospitalist leader to reduce cost and quality variation across hospitalist programs
- System hospitalist leader analyzes causes of variation to define appropriate program standards

Source: Mount Sinai Health System, New York, NY; Physician Executive Council interview and analysis.

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The first challenge the system hospitalist leader encountered was defining the causes of variation between the facility-level hospitalist programs. For example, while some variation was the result of the hospitalist group’s performance, other variation was due to facility-level differences, such as different patient populations and services provided.

The hospitalist leader conducted a detailed audit of all of the different points of variation. This allowed him to determine what could be standardized, and corresponding performance expectations.

After a particular type of variation was identified, the hospitalist leader worked to define the structural reason for the variation. For example, use of nocturnists at some facilities led to lower RVU per hospitalist ratios. Once the difference was identified, the hospitalist leader could choose to either adjust the performance metric to control for the variation, or work to standardize the hospitalist program structure.

In the example cited above, instead of standardizing the program by deploying nocturnists to each facility, he adjusted the productivity metrics for each site, depending on the use of nocturnists.

Mount Sinai’s Process for Setting Common Standards

Heat Map of Main Areas of Variation

Review of facility-level hospitalist variation identifies variable performance in:
- Productivity
- Throughput
- Quality and Outcomes
- Resource Utilization

Cataloging Underlying Hospitalist Program Differences

Assessment of structural differences causing variation between facilities, including:
- Average patient census and case-mix index
- Hospitalist schedule and scope of role
- Additional clinical support available
- Administrative support available

Selection of Actionable System-Wide Hospitalist Performance Metrics

Identification of metrics that measure true performance variation, regardless of program differences

- OR -

Standardization of Hospitalist Program Structures

Implementation of new standard that reduces structural variation between hospitalist programs

Source: Mount Sinai Health System, New York, NY; Physician Executive Council interview and analysis.
Reaping Benefits of Cross-Facility Standardization

Standardization allows for more meaningful comparisons of quality performance across sites, while also enabling rapid identification and deployment of pilots across the system.

Because the quality metrics between sites reflect more of an “apples to apples” comparison, it’s easier for leaders to know whether a pilot test undertaken in one facility is worth replicating in others. Additionally, it’s easier to scale a successful pilot because the sites are more standardized.

Benefits of Cross-Facility Standardization at Mount Sinai

Greater Structural Standardization
- Less variable workload and process across sites enables single compensation system
- More consistent administrative and program support across sites

Rapid Best Practice Sharing
- Comparable quality metrics enable identification of potential best practices
- Standardized structure supports pilot testing and rapid roll-out of best practices

Preparing for Standardization

“Quality and value were the driving forces to make our hospitalist programs more standardized and aligned. You don’t know how each program is doing until you can compare them, but you can’t compare them until you know how they’re different.”

Andrew Dunn, MD
Chief of Hospital Medicine, The Mount Sinai Health System

Source: Mount Sinai Health System, New York, NY; Physician Executive Council interview and analysis.
Effective hospital-hospitalist alignment is about more than agreeing to performance incentives or targets for quality metrics. Hospitalists must understand the organization’s broader priorities, and hospital executives must prioritize where they need hospitalist support most.

At Carolinas HealthCare, health system executives and hospitalist leaders had no consistent process for identifying and discussing priorities. Carolinas Hospitalist Group was initially focused on facility-level goals and needs instead, evolving their service model to support what they heard from facility leaders. The hospitalist group was performing on the metrics they were asked to target, including referring physician satisfaction. However, these goals were not consistently connected to the health system executives’ priorities. As the cost of the program increased, system executives began to question the investment in the program, despite strong hospitalist performance on agreed upon performance metrics for each facility.

Initially Missing System-Level Priorities at Carolinas Hospitalist Group

Hospitalist Group Unaware of Larger Health System Priorities

Hospitalist group meets with facility-level leadership on a regular basis

Health system executive leadership still questions hospitalist program value

Hospitalists make improvements on specific facility challenges, like referring physician satisfaction

Not on Same Page

“We thought we were doing what was right for the organization, but it turns out we didn’t understand what [the health system] actually needed from us.”

Scott Rissmiller, MD
President, Carolinas Hospitalist Group

Case in Brief: Carolinas Hospitalist Group

- Employed hospitalist group of Carolinas HealthCare, a 42-hospital health system based in Charlotte, North Carolina; group currently operates at 22 sites and employs 150+ hospitalists
- In 2005, Carolinas Medical Center funded hospitalist group to cover unassigned patients, increase referrals from other physician practices, and support hospital quality improvement
- Advisory Committee developed to connect hospitalist leaders to facility-level hospital executives
- Rising facility demands require additional financial support and system executives increasingly question value of the program
- In 2009, visioning sessions with health system and hospitalist leaders allowed both parties to set shared goals and priorities, as well as develop a plan to achieve these goals
- Results in greater alignment between hospitalist group and health system; hospitalist leadership both more aware of and engaged in achieving broader system goals

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.
To build a shared vision for the program, hospitalist team leaders and health system executives attended a retreat to first establish a shared vision for the program, and then identify gaps and resources required to achieve the vision.

The success of the retreat was due in large part to extensive self-assessments done in advance. Before the retreat, hospitalist and health system leaders met separately to answer a set of questions about the role of the hospitalist program, and opportunities for improvement. A facilitator compared feedback from each session, identifying the biggest gaps and a prioritized list of improvement opportunities.

They reviewed the results at the retreat, and developed shared goals and priorities for the program. They also decided how to resource high-priority improvement efforts.

The results of the discussion were used to define a shared improvement plan.

---

**Carolininas Hospitalist Group’s Visioning Session**

**Assess Current Perceptions**

*Leaders separately discussed the following questions:*
1. What is the primary purpose of the hospitalist program today? What should it be in the future?
2. What are the strengths and weaknesses of the hospitalist program?¹
3. What are the opportunities for the program to improve?¹

**Establish Shared Program Direction**

- Facilitated group session compares different leaders’ views on purpose and performance of hospitalist program
- Develops shared definition of hospitalist program value
- Establishes shared prioritization of opportunities to improve and where to invest hospitalist resources

**Define Plan for Improvement**

- Identifies seven action planning areas aligned with hospitalist program vision and health system goals
- Identifies champions from both health system and hospitalist leadership to support implementation of vision

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¹ Also polled the Medical Executive Committee on these two questions.

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.

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The shared hospitalist program improvement plan focused on seven improvement themes identified in the retreat. For each theme, a detailed list of proposed actions and progress milestones was proposed. A member from both the hospitalist and health system teams was assigned to each action to ensure shared accountability.

### Carolinas’ Hospitalist Management Action Plan

<table>
<thead>
<tr>
<th>Hospitalist Management Action Plan Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
</tbody>
</table>

#### Action Item
- Lists a specific goal as well as granular steps that must be completed (example: “con duct detailed drill down of survey data to identify opportunities to improve”)

#### Progress
- Lists anticipated completion date, progress, and/or barriers to completion

#### Responsibility
- Tags both a hospital and hospitalist champion responsible for progress

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.
Because establishing a shared vision for the hospitalist program is critical but often difficult to do, the Physician Executive Council collaborated with the Society of Hospital Medicine to create a Hospitalist Program Gap Assessment. This tool helps hospital and hospitalist leaders compare their program to key characteristics of high-performing hospitalist programs. In doing so leaders can prioritize areas for improvement and identify the resources required to improve.

The assessment is based on the Society of Hospital Medicine’s “Key Principles and Characteristics of an Effective Hospital Medicine Group” authored by hospitalist leaders and experts over a two-year process, and pilot tested by over 25 groups nationwide.

This tool is a starting point for an informed discussion between hospital executives and hospitalist leaders on key improvement opportunities for the hospitalist program.

### Introducing the Hospitalist Program Gap Assessment

#### Excerpt from the Hospitalist Program Gap Assessment Tool

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospitalist program is aligned with the hospital and/or health system</td>
<td>3.80</td>
<td>Needs improvement</td>
</tr>
<tr>
<td>The hospitalist program takes a thoughtful and rationale approach to the scope of clinical activities</td>
<td>3.80</td>
<td>Needs improvement</td>
</tr>
<tr>
<td>The hospitalist program plays a leadership role in addressing key clinical issues in the hospital and/or health system, such as teaching, quality, safety, efficiency and the patient/family experience</td>
<td>2.80</td>
<td>Needs improvement</td>
</tr>
<tr>
<td>The hospitalist program has a practice model that is patient- and family-centered, team-based, and emphasizes effective communication and care coordination</td>
<td>2.50</td>
<td>Needs improvement</td>
</tr>
<tr>
<td>The hospitalist program actively works to support care coordination across care settings</td>
<td>3.80</td>
<td>Needs improvement</td>
</tr>
</tbody>
</table>

#### Physician Executive Council Tool in Brief: Hospitalist Program Gap Assessment

- 45-question assessment allows leaders to compare their current hospitalist program to key characteristics of effective hospital medicine groups
- Enables hospital executives and hospitalist leaders to establish a shared view of program gaps and resources needed to improve
- Characteristics defined over three years by top hospitalist leaders and experts, tested by 26 hospitalist groups nationwide
- Download the tool from advisory.com/pec/hospitalisttoolkit

Source: Society of Hospital Medicine, *The Key Principles and Characteristics of an Effective Hospital Medicine Group* 2015, www.hospitalmedicine.org/KeyChar
Once hospitalist program and health system goals and priorities are aligned, hospitalist leaders must be positioned to make program management decisions that maintain that alignment.

Hospitalist leaders often report to either facility or medical group leaders who may not be accountable for the broader goals and priorities of the hospital or health system. For example, a facility CMO may request hospitalist program staffing or resource changes, such as a service expansion, that make it difficult for hospitalists to focus on achieving health system quality and cost goals. Similarly, medical group leaders may prioritize improved productivity metrics over improved inpatient quality metrics. These small conflicts of interest make it difficult for the hospitalist leader to make program management decisions that are aligned with the agreed health system priorities and goals.

The results from our hospitalist survey reflect this disconnect—just over half of CMO respondents don’t have direct accountability for the hospitalist program, while 30% said they don’t think hospitalist leaders effectively balance hospitalist and organizational needs.

Difficult for Hospitalist Leaders to Define and Balance Competing Needs

Disconnected Leaders with Different Priorities

Limited Connectivity Between Hospitalist, System Leaders

Hospitalist Leader  Facility or Medical Group CMO  System Hospitalist Leadership or CMO

Indirect communication

Different Leaders, Different Needs

Hospitalist Engagement and Retention  Program Cost and Efficiency  Clinical Quality and Standardization

Executives\(^1\) Say Hospitalist Leadership Not Ideal

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>Lack direct accountability over hospitalist program</td>
</tr>
<tr>
<td>30%</td>
<td>Don’t think hospitalist leaders effectively balance hospitalist and organizational needs</td>
</tr>
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</table>

\(^1\) CMO, CMIO, CQO, CCO, VPMA respondents, n=33.
Connecting Hospitalists, Facility and System Leaders

However, it is possible to position hospitalist leaders to balance potential conflicts between different stakeholders, as demonstrated in Carolinas Hospitalist Group’s leadership structure.

Each facility has a site hospitalist leader who reports directly to system-level hospitalist leadership, but who is expected to frequently collaborate with the facility CMO. Site hospitalist leaders better understand facility-specific challenges, but are ultimately accountable for finding solutions that work for both the system and the facility.

There are important structural elements of the site hospitalist leader role that make it effective. Site leaders have dedicated administrative time, depending on the size of the program they manage. Reporting lines are structured to position hospitalist leaders as a service partner to facility CMOs as opposed to a staffing vendor providing hospitalist coverage.

Hospitalist leaders are given autonomy to make decisions, but are expected to find solutions that meet both facility and system needs, with support from a group of system hospitalist leaders and hospitalist leader colleagues.

### Carolinas Hospitalist Group Site Leaders Maintain Alignment

#### Site Hospitalist Leadership Structure

- System Hospitalist Leadership
- Facility CMO
- Site Hospitalist Leader
- Facility Hospitalists

#### Key Elements of Site Hospitalist Leader Role:

1. **Site Leaders Have Dedicated Administrative Time**
   Site leaders spend 80% of their time on clinical care, and have 20% reserved for administrative support.

2. **Site Leaders Positioned as Service Partner, Not Service Vendor**
   Site leaders collaborate with facility leaders on program needs, but ultimately report to system hospitalist leaders.

3. **Balanced Autonomy and Accountability**
   Site leaders have decision-making authority and are held accountable for performance.

4. **Supported by Hospitalist Operating Committee**
   Site leaders meet weekly with other hospitalist leaders to share challenges and discuss system needs.

### Case in Brief: Carolinas Hospitalist Group

- Employed hospitalist group of Carolinas HealthCare, a 42-hospital health system based in Charlotte, North Carolina; group currently operates at 22 sites and employs 150+ hospitalists.
- In 2007, asked to extend coverage from flagship hospital to community facilities.
- Initially, many community hospitals had CMOs as acting hospitalist leaders, making it difficult to build cohesive group aligned with system priorities.

- Established site hospitalist leader (0.2 FTE) in each facility to oversee hospitalist team and connect facility and system hospitalist leaders.
- Structure elevates conflicts as they arise; supports collaboration and standardization across sites.

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.
System-Wide Structures Support Site Leaders

A strong system leadership structure, shown here, is ultimately what helps Carolinas Hospitalist Group maintain alignment with system goals while supporting facility needs.

Carolinas Hospitalist Group has over 150 hospitalists across 22 different sites, making it impossible for the system-level hospitalist leader to make the call at each site effectively. Site leaders must have autonomy to make decisions about the program, but also rely on regional hospitalist leaders for advice and support.

Hospitalist site leaders all serve on a hospitalist operating committee that includes both system and site hospitalist leaders. This operating committee acts as a sounding board for site leaders who need to find solutions that meet both facility and system needs, as portrayed here. This operating committee structure also enables system hospitalist leaders to rapidly identify common themes and challenges across facilities in order to adjust the program across sites when needed.

Dedicated hospitalist site leaders and a system leadership structure are critical for hospitalist programs seeking to maintain alignment while supporting multisite health systems.

Reporting Structure Ensures Consistent Alignment, Connectivity at Carolinas

System Reporting Structure Ensures Alignment Across Hospitalist Group

All site leaders serve on CHG¹ Operating Committee

Operating Committee Structure Helps Site Hospitalist Leaders Balance Competing Needs

Facility CMO requests new type of hospitalist support and staffing

Site leader identifies potential solution; secures buy-in from hospitalists and needed resources from health system

Implements solution that supports facility needs with broader health system priorities

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.

¹) Carolinas Hospitalist Group.
To support productive discussion about hospitalist alignment within your organization, consider these key questions.

### Realign Hospitalists with Hospital Priorities

#### Key Questions for Physician Executives

1. How much variation exists between different hospitalist groups working across our facility or health system? Have we cataloged the sources of variation and prioritized what we hope to standardize?

2. If applicable, have we implemented a minimum set of standards to reduce variation between multiple hospitalist groups and/or different facilities?

3. Is our hospitalist program aligned to top-level organizational priorities? Do we have a governance structure or committee that brings together different hospitalist leaders and key executive leaders?

4. Does our executive team understand what a best-in-class hospitalist program looks like, and the value of such a program?

5. Have we assessed our hospitalist program compared to an ideal program? Do we have a shared view of performance gaps and resources required to improve the program?

6. Have we positioned our hospitalist leaders in roles that balance competing stakeholder needs?

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Source: Physician Executive Council interview and analysis.
Optimize Hospitalist Role

- Imperative 4: Refine medical comanagement model to maximize hospitalist impact
- Imperative 5: Evaluate opportunities to develop specialized roles for hospitalists
- Imperative 6: Ensure ROI from advanced practitioner hospitalist roles
- Imperative 7: Weigh dedicated RN support to increase hospitalist efficiency
Many hospital executives are focused on identifying an appropriate benchmark to determine ideal hospitalist staffing levels, but benchmarks fail to incorporate site-specific variation that can impact hospitalist productivity. To be effective, benchmarks must be adjusted to recognize organization-specific factors.

As a starting point, some research suggests 15 patients per hospitalist per shift. That number must be adjusted based on many other factors, including patient complexity and resources available to the hospitalist program, such as the presence of APs.

Some experts suggest that the best way to determine the ratio of hospitalists to patients is to follow a hospitalist team member around for an entire shift to get a sense of the workflow supports, challenges, and what patient census is feasible.

Hospital Leaders Seek “Best-Practice Benchmark”

Hospitalist-Specific Benchmarks Requested by Members

“Can you send us a benchmark that shows the number of hospitalists needed for a 150-bed hospital?”

“Our COO says we have too many hospitalists, but our hospitalists say they don’t have enough capacity. Can you send a benchmark that will finally settle the debate?”

Benchmarks Aren’t One Size Fits All

Research suggests a ratio of about 15 patients per hospitalist, but the ratio must be adjusted based on multiple factors, including:

- Patient population
- Hospitalist training and experience plus support available
- Shift length
- Services provided

When evaluating hospitalist productivity, it’s critical to consider more than benchmarks and staffing ratios. Hospitals must clearly define a rational clinical scope for the hospitalist team. Organizations focused too narrowly on productivity may fail to consider whether the services hospitalists are regularly asked to provide are valuable. High-performing hospitalist programs ensure hospitalists work on high-value, top-of-license activities.

As an example, a time-study of a single academic hospitalist group found hospitalists spend most of their time on the EMR and non-patient (and non-family) communication. Hospitalists spent only 17% of their time on direct patient care. This data was reinforced anecdotally, as many hospitalist leaders report that the burden of administrative care tasks they are asked to provide forces them to work far below their license.

This research suggests an opportunity to more carefully evaluate hospitalist work, and establish more efficient supports for hospitalists so they can stay focused on high-value tasks.

### Change the Conversation: Not How Many, but How Are Hospitalists Used?
- Where do hospitalists spend most of their time in our hospital or system?
- How is their role defined with specialists? With other clinical teams?
- Are we getting the outcomes or returns we want from the current model?
Increasing Urgency to Define Hospitalist Role

Three trends make it more urgent than ever for hospitalists to clearly define the scope of hospitalist work:

• Hospitalists are facing increased demand from specialists to comanage chronic medical conditions, such as diabetes

• Specialists are increasingly focused on outpatient practice, and are often less willing to support the development of specific care protocols, leaving a gap hospitalists are equipped to fill

• Because of increasing financial pressure, hospitalist programs are hiring non-physician providers but often fail to define and delineate the respective responsibilities of APs and hospitalists

To overcome these challenges, physician executives must help hospitalists manage and refine clinical comanagement agreements, evaluate specialized roles for hospitalists, and ensure appropriate ROI from advanced practitioners and dedicated RN support.

Three Trends Accelerating Evolution of Hospitalist Role and Scope

- Increased specialist demand for hospitalist consults

- Specialists less involved in leading or establishing care protocols

- Growing use of non-physician support to increase hospitalist capacity

Imperative #4
Refine medical comanagement model to maximize hospitalist impact

Imperative #5
Evaluate opportunities to develop specialized roles for hospitalists

Imperative #6
Ensure ROI from advanced practitioner hospitalist roles

Imperative #7
Weigh dedicated RN support to increase hospitalist efficiency

Source: Physician Executive Council interviews and analysis.
Hospitalist medical comanagement results are somewhat mixed, with some studies finding medical comanagement improves quality metrics, while other studies show limited impact. The impact on resource utilization and cost is also mixed.

More recent research suggests that medical comanagement may only be valuable for high-risk patients with multiple comorbidities who need greater care coordination.


Focusing on High-Risk Patients Most Impactful

Reduced the incidence of minor complications but did not reduce major complications or mortality

Reduced costs, but did not impact readmission rates, length of stay, or mortality

Reduced observed-to-expected length of stay, but did not reduce cost of care

Focusing on the High-Risk Patients

Recent studies suggest that the benefits of medical comanagement may be limited to high-risk surgical patients with complex medical or care coordination issues.”

Eric Siegal, MD
“A Structured Approach to Medical Comanagement of Surgical Patients”
The Mount Sinai Hospital in New York developed a more focused medical comanagement program for vascular surgical patients that improved outcomes by targeting hospitalist support to the most complex patients.

Before this change, Mount Sinai’s vascular surgeons were requesting medical consults for most cases, regardless of patient complexity. Hospitalists provided a pre-op note for all patients, even when this service was ultimately low value to the hospital, but convenient for surgeons.

With hospitalists already stretched thin, the hospitalist leader decided to adjust the comanagement agreement to target patients who would benefit most from hospitalist care.

### Overuse of Hospitalists for Medical Consultation at Mount Sinai

#### Case in Brief:
The Mount Sinai Hospital
- 1,171-bed academic medical center in New York, New York; all hospitalists are employed
- In January 2013, initiated medical comanagement agreements for highest-acuity patients, beginning with vascular patients
- Hospitalist and vascular surgeon champions together developed agreement with clearly delineated responsibilities
- Comanagement agreement resulted in decreased readmissions rate and mortality

#### Surgeons Not Maximizing Hospitalist Expertise
- Surgeons request hospitalist consult for nearly every case
- Hospitalists write pre-op notes, even for low- and medium-acuity patients
- Hospitalists stretched thin and lack proper bandwidth to target high-acuity patients
- Only added value is surgeon convenience; hospitalists feel frustrated, underutilized

Source: The Mount Sinai Hospital, New York, NY; Physician Executive Council interviews and analysis.
Mount Sinai used a four-step approach to refine their medical comanagement agreements, ensuring hospitalist support was targeted to provide high-value care.

First, hospitalist leaders clearly defined the patient population that would benefit most from medical consults. In this case, mortality data identified high-acuity vascular surgery patients as an area of focus.

Second, they designated a specific hospitalist champion and a vascular surgery champion who would oversee the agreement and ensure both groups adhered to it.

Third, these champions made sure the agreement was very specific, with clearly delineated roles and responsibilities. For example, surgeons would make decisions on pain management issues, not hospitalists.

Finally, the agreement stipulated the champions would monitor quality results compared to the goal; if quality goals are not achieved, champions continue to adjust the agreement to achieve better outcomes.

Targeting High-Risk Patients for Comanagement

Four-Step Approach Creates High-Value Medical Comanagement Agreements

1. Identify patient population where hospitalist support is most needed (in this case, high-acuity vascular surgery patients)
2. Designate hospitalist and vascular surgeon champions
3. Champions create highly specific, delineated comanagement agreements with clinical outcomes in mind
4. Compare actual outcomes to goal; update comanagement agreement as needed

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Assigned Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate recommendations for plan of action and treatment to house staff and other surgery providers</td>
<td>Hospitalist</td>
</tr>
<tr>
<td>Communicate with patients and their families regarding the medical plan of care, goals, treatments, and options</td>
<td>Hospitalist</td>
</tr>
<tr>
<td>Actively manage all medical comorbidities (diabetes, chronic kidney disease, COPD¹, anticoagulation, etc.)</td>
<td>Hospitalist</td>
</tr>
<tr>
<td>Answer calls from the nursing staff when problems arise</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Decide on pain management issues</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Call in subspecialist consultations</td>
<td>Hospitalist and surgeon in collaboration</td>
</tr>
</tbody>
</table>

¹) Chronic Obstructive Pulmonary Disorder.

Source: The Mount Sinai Hospital, New York, NY; FOJP Service Corporation, "FOJP Initiatives: Preoperative Medical Assessment and Comanagement of Surgical Patients," infocus: The Quarterly Journal for Health Care Practice and Management, 21 (2013), 16-17, [http://www.fojp.com/sites/default/files/InFocus_Spring13_0.pdf](http://www.fojp.com/sites/default/files/InFocus_Spring13_0.pdf); Physician Executive Council interviews and analysis.
Mount Sinai’s focused comanagement agreement led to improvements in both risk-adjusted mortality and readmissions rate for vascular surgery patients. The agreement also improved hospitalist satisfaction, as their support is focused on quality outcomes as opposed to managing all requests.

Mount Sinai continues to improve their medical comanagement agreements, partnering with other specialties such as surgical oncology.

Updated Agreement Produces Significant Results

Vascular Surgery Results Before and After Comanagement Agreement

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-Adjusted Mortality</td>
<td>1.02</td>
<td>0.63</td>
</tr>
<tr>
<td>Readmissions Rate</td>
<td>23.1%</td>
<td>20.2%</td>
</tr>
</tbody>
</table>

Source: The Mount Sinai Hospital, New York, NY; Physician Executive Council interviews and analysis.

We started with the vascular surgery patients because they were the sickest, and our results suggest that a highly structured comanagement program targeting these patients can have a substantial impact on patient care. ”

Andrew Dunn, MD
Chief of Hospital Medicine, Mount Sinai Health System
Effective medical comanagement agreements have three consistent characteristics: well-defined target outcomes, explicit roles and processes, and designated hospitalist and specialist champions to ensure adherence.

To optimize medical comanagement, organizations should review existing agreements first, ensuring they have these three characteristics. Then, consider expanding medical comanagement to other clinical areas where there is a significant opportunity to improve outcomes.

Optimize Hospitalist Role with Effective Medical Comanagement

Key Characteristics of Effective Medical Comanagement Agreements

Well-Defined Target Outcomes
Allows for clear comanagement goals and determination of success

Explicit Roles and Process
Clearly defined patient criteria, defined role for each specialty (who handles discharge paperwork, etc.), and clear process when disagreements occur

Equal Representation
Designated specialist and hospitalist leaders define a fair, balanced agreement and use influence with their peers to achieve widespread buy-in

Questions to Assess Medical Comanagement Performance at Your Organization

- Are our hospitalists providing high-value expertise in an effective, targeted way?
  - Monitor average acuity of comanaged patients and compare to original target criteria

- What are our target goals for hospitalist medical comanagement? Are we reaching them?
  - Identify specific outcomes to monitor success, such as risk-adjusted ALOS\(^1\), risk-adjusted mortality, readmissions rate, complications (CAUTI\(^2\), VTE\(^3\) prophylaxis, infections not present on admission)

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1) Average length of stay.
2) Catheter-associated urinary tract infection.
3) Venous thromboembolism.

Source: Physician Executive Council interviews and analysis.
Limited Clinical Standardization Impacts Hospital, Hospitalists

When specialists are unavailable or unwilling to support care standardization efforts in the hospital, there is an opportunity for hospitalists to help define and improve adherence to a clinical standard.

At Middlesex Hospital in Connecticut, each orthopedic surgeon had a different set of care protocols for joint replacement surgeries, making it difficult for hospitalists to adhere to a consistent standard when providing perioperative support.

This variation was linked to additional complications, and also led to high OR cancellation rates.

Orthopedic Surgical Variation at Middlesex Hospital

Each surgeon follows different care protocols for similar surgeries and patients

Hospitalists have no single process to follow; yield variable and low-value support

- High surgery cancellation rate and inefficiency
- Inconsistent adherence to P4P\(^1\) measures
- High complication rate penalizes hospital

Case in Brief: Middlesex Hospital

- 275-bed hospital in Middletown, Connecticut
- High complication and surgery cancellation rates, along with unclear hospitalist role in comanagement, led to development of Perioperative Evaluation Assessment Center (PEAC), staffed by perioperative hospitalist and AP\(^2\)
- PEAC reduced complications and cancellations and increased care pathway standardization

1) Pay-for-performance
2) Advanced Practitioner

Source: Middlesex Hospital, Middletown, CT; Physician Executive Council interviews and analysis.
Creating a Dedicated Hospitalist Role to Standardize Perioperative Care

Middlesex’s dedicated perioperative hospitalist role ensures all patients receive the same level of care while enabling hospitalists and surgeons to work together more effectively.

The dedicated perioperative hospitalist works closely with the orthopedists to develop standardized protocols to reduce variation. Having a more standardized care pathway also allows the hospitalist team to leverage AP support more effectively. The perioperative hospitalist oversees the APs and ensures adherence to the agreed-upon clinical standards.

For Middlesex, this is a dedicated (as opposed to rotational) role. The perioperative hospitalist works from 7 a.m. to 3 p.m., Monday through Friday, rounding on many of the orthopedic surgery patients.

Defining the Perioperative Hospitalist Role

Middlesex’s Perioperative Hospitalist Role Develops Protocols, Ensures Adherence

1. Develops standardized protocols that maximizes hospitalist and AP1 roles
2. Educates hospitalists on perioperative management and protocols

- Orthopedists
- Perioperative Hospitalist
- Other Hospitalists
- AP

Completes pre-op assessments (H&P2, risk assessment) formerly done by hospitalists

Perioperative Hospitalist Role

- Full-time role; works 7 a.m. to 3 p.m. Monday through Friday
- Oversees Perioperative Evaluation Assessment Center (PEAC)
- Geographically based on orthopedic surgery floor to round on all orthopedic surgery patients
- 20% of time dedicated to managing AP resources
- Participates in monthly meetings with orthopedic surgeons and anesthesiologists; leads monthly education sessions with hospitalists

Source: Middlesex Hospital, Middletown, CT; Physician Executive Council interviews and analysis.

1) Advanced practitioner
2) 14 orthopedic surgeons in three different groups
3) History and physical
Creating a dedicated perioperative hospitalist allowed Middlesex to convene orthopedic surgeons from different groups to discuss how to realize quality and efficiency improvements. The resulting clinical standards led to fewer surgery cancellations and post-operative complications.

The perioperative hospitalist also strengthened the hospital’s relationship with orthopedic surgeons. The surgeons view the dedicated perioperative hospitalist as an extended member of their team, making it easier for the hospitalist to build consensus for a particular standard. The perioperative hospitalist also increased perioperative expertise across the hospitalist team by sharing regular updates on perioperative best practices.

**Perioperative Hospitalist Role Improves Quality and Efficiency**

**Benefits from Middlesex’s Perioperative Hospitalist Program**

- **Drops in complications and cancellations**
  - Reduced both post-op complications and last-minute surgery cancellations

- **Increased orthopedic care pathway standardization**
  - Perioperative hospitalist developed hospital protocols for medical management of orthopedic patients

- **Improved communication**
  - Perioperative hospitalist serves as liaison between orthopedic surgeons and hospitalists; surgeons consider her to be a part of their team

- **Increased perioperative knowledge sharing**
  - Perioperative hospitalist provides updates on perioperative management to hospitalist group and gives individual feedback to hospitalists as needed

Source: Middlesex Hospital, Middletown, CT; Physician Executive Council interviews and analysis.
Identify and Evaluate Opportunities to Create Specialized Hospitalist Roles

A specialized hospitalist role can provide valuable support, but to ensure the role is valuable, it must be targeted to solve a specific, high-priority challenge where hospitalists have the capacity and skills to assist.

To evaluate opportunities for specialized hospitalist roles, leaders should start by identifying a specific performance opportunity where improved quality or efficiency can have an outsized impact. For example, high-volume DRGs with variable outcomes and cost such as joint replacement are often a good starting point. Leaders should also consider services in need of higher referring physician satisfaction, or areas where greater standardization can significantly improve efficiency, such as observation units.

Then, leaders should consider the hospitalist skills and capacity within the program to support a specialized role. In Middlesex’s case, they had an experienced hospitalist who wanted to transition to a part-time role and was interested in perioperative management. Alternatively, roles that require less continuity (where protocols are already set) may be conducive to a rotational schedule where hospitalists take turns covering the role.

Two-Step Process: Evaluating Opportunity for Specialized Hospitalist Roles in Your Organization

1. Identify potential areas where dedicated hospitalist support may be needed

   **DRG performance outliers**
   Highly variable, high-volume DRGs where specialists haven’t established a single care pathway (example: joint replacement)

   **Service line-specific opportunities**
   Areas where greater referring physician satisfaction or hospital efficiency are needed (example: observation unit hospitalist)

   **Payer-identified opportunities or priorities**
   Some insurance companies are investing in specialized hospitalist roles that support complex, high-cost patients in a particular disease area (example: one insurer funded a vascular comanagement hospitalist)

2. Consider hospitalist capacity and skills available

   **Questions to Ask:**
   - Do we have the capacity and/or investment available to support this role?
   - Do we have a hospitalist who is both interested and has the right skill set for this role?
   - How will the role be structured?

   **Rotational roles:** Good for roles where less continuity with specialist physicians is needed (protocol heavy, no unique schedule)

   **Fixed roles:** Ideal when a hospitalist is interested in a fixed, unique schedule and focusing more narrowly in a particular disease area or patient type

Source: Physician Executive Council interviews and analysis.
The use of advanced practitioners (APs) in hospitalist programs, including both nurse practitioners and physician assistants, is increasing. Using APs can lead to productivity and efficiency gains, but only when they are in roles that allow them to fully use their skills and experience to work more autonomously.

Defining a role for APs that effectively balances autonomy with required physician oversight can be difficult. Poorly scoped AP roles can force the AP to work below license, which wastes resources. Roles that stretch APs beyond their skills and capabilities can lead to burnout and turnover.

Use of Hospitalist Advanced Practitioners Rising

But Often Struggling to Use Them Effectively

Hospitalist Groups Using Advanced Practitioners (APs)¹

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2012</td>
<td>53.9%</td>
</tr>
<tr>
<td>2014</td>
<td>65.5%</td>
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</table>

Common Challenges to Using APs Within the Hospitalist Program

Setting Appropriate Scope
APs’ limited diagnostic skill set is a barrier to full autonomy, but ensuring consistent top-of-license work is difficult.

Right-Sizing Physician Oversight
APs’ skill and experience varies, making it difficult to standardize physician oversight.

Patient Assignment
Physicians hesitant to pass all low-acuity patients to APs; AP capability to provide higher acuity patient care highly variable.

¹ Advanced practitioners defined as nurse practitioners (NPs) and/or physician assistants (PAs).

There is no one-size-fits-all approach to high-value AP use. However, there are four characteristics effective AP roles have in common.

Effective AP roles do not require diagnostic skills, which are outside the AP skill set. They also have detailed clinical protocols that allow APs to work independently. Many effective AP roles are disease specific, allowing APs to build deep expertise in a particular clinical area. Finally, effective AP roles minimize the amount of physician oversight required, to ensure the roles are cost effective.

CMOs and hospitalist leaders should review their use of APs to ensure AP roles have these characteristics. For instance, some organizations that effectively leverage APs have done so in observation units and disease-specific consult services—in both instances, APs work autonomously while freeing up hospitalists to provide more complex support.

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### Four Characteristics of Effective AP Roles

**Characteristics of Effective AP Roles in Hospital Medicine**

- Non-diagnostic
- Has detailed clinical protocols
- Disease specific
- Allows for cost-effective balance of autonomy and oversight

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### Examples of Effective AP Use

1. **Observation unit**
2. **Disease-specific consult services:**
   - Psychiatric
   - Heart failure
   - Diabetes
3. **Disease-specific protocolized units:**
   - Bone marrow transplant unit

---

At Sacred Heart Medical Center, it took several attempts to find roles that were the right fit for APs.

Initially, Sacred Heart used NPs during admissions to complete history and physicals. They also deployed NPs to care for low-acuity patients in general inpatient rounds. However, both roles were ineffective. In some cases, NPs lacked the expertise to work with variable patients effectively. As a result, hospitalists would sometimes replicate the NP’s workup or diagnostic task, leading to reduced NP engagement and turnover.

To improve NP effectiveness, the hospitalist program created a specialized role on the diabetes consult service. NPs on the consult service developed specific protocols to oversee diabetic surgery patients, reducing the need for hospitalist oversight. This model has been effective for both hospitalists and NPs. NPs can work autonomously, and hospitalists have more time to spend on complex cases.

Sacred Heart then created an NP-supported consult service for psychiatric patients. When psychiatrists call for a medical consult, they get a trained NP in the psychiatric ward who is able to care for the patient’s comorbid medical condition.

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**Sacred Heart Tries Nurse Practitioners in Variety of Roles**

**Evolving Use of Hospitalist NPs Over Three Years**

- **Admissions H&Ps**
  - NPs lacked the breadth of expertise required for the level of complexity of patients at Sacred Heart

- **Diabetes Consult Service**
  - Condition-specific consult service where NPs develop protocols for diabetic surgery patients under part-time hospitalist oversight

- **Hospital Rounding**
  - Too few patients that NPs could care for autonomously to justify NPs for use in hospital rounding

- **Psychiatric Consults**
  - NPs complete medical consults on patients with psychiatrics DRGs

**Case in Brief: Sacred Heart Medical Center**

- 642-bed hospital in Spokane, Washington
- Part of Providence Health and Services; hospitalists employed by Providence Medical Group
- Three diabetic management NPs in hospitalist group develop care protocols for diabetes-specific consult service with physician oversight; two psychiatric NPs in hospitalist group perform medical consults on patients with psychiatric DRGs

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1) History and physicals.
2) Nurse practitioners.

Source: Sacred Heart Medical Center, Spokane, WA; Physician Executive Council interviews and analysis.
Targeted Nurse Practitioner Roles Reduce Turnover, Improve Outcomes

The new, more targeted AP roles at Sacred Heart have a few elements in common which secure key benefits.

NPs in both roles receive role-specific training, which allows them to work autonomously, and increases engagement. The NPs are directly managed by the hospitalist team, ensuring they have ongoing connectivity with hospitalists. NPs care for approximately 14 to 20 patients per shift, including new consults. This patient load makes them a cost effective support to the hospitalist program.

While it took Sacred Heart time to identify the service and deployment model for their NPs, it has resulted in significant gains in NP satisfaction and reduced turnover. The new roles have also yielded quality gains, reducing the infection rate for surgical patients with diabetes and allowing psychiatric patients to stay in the psychiatric ward even when they have comorbid medical conditions.

Details and Benefits of Sacred Heart’s Hospitalist Nurse Practitioner Roles

### KEY ELEMENTS

- NPs receive role-specific training from either DM\(^1\) hospitalist or psychiatric NPs
- NPs managed directly by hospitalist team
- NPs care for approximately 14-20 patients, including new consults

### BENEFITS

- Improved NP satisfaction and reduced turnover since implementation
- Improved quality and reduced infection rate for complex surgical diabetes patients\(^2\)
- Able to keep psychiatric patients in psychiatric ward, regardless of comorbidities

---

1) Diabetes Management
2) Reduced infection rate observed in open-heart and vascular surgery patients after DM-NP role implemented.
Leaders can use a simple analysis to understand whether the organization’s use of APs is cost effective.

First, compare the cost of an AP to the cost of a hospitalist to understand how the productivity of an AP should roughly improve hospitalist productivity.

Then use this ratio to understand the productivity gain APs should provide. For example, if APs are half the cost of a hospitalist, having an AP should be like having half of an additional hospitalist FTE.

Finally, compare productivity with and without APs to ensure APs provide the value expected. If APs are not providing the value expected, consider adjusting their role to ensure it meets the characteristics listed on page 55.

Three-Step Analysis for Assessing Hospitalist AP ROI

1. **Identify Hospitalist, AP Cost**
   - Compare full cost of hospitalists (including benefits) to full cost of AP
     
     **Example**
     
     **Hospitalist:** ~$275,000
     
     **AP:** ~$138,000
     
     **2 APs = 1 Hospitalist**

2. **Convert AP capacity into FTE hospitalist capacity**
   - Use AP/hospitalist cost ratio to calculate the estimated hospitalist FTE equivalent
     
     **Example**
     
     **10 hospitalists + 4 APs = 10 hospitalists + 2 hospitalists = 12 hospitalists total**

3. **Ensure Return on Investment**
   - Ensure productivity of overall group is equivalent to hospitalist productivity
     
     **Example**
     
     **Productivity of 10 hospitalists + 4 APs should equal productivity of 12 hospitalists**

"90% to 95% of hospitalist programs that have APs are not getting the necessary ROI. APs are a great value add, but need to be managed correctly."

**John Nelson, MD**

**Nelson Flores Hospital Medicine Consultants**

**Cofounder and Past President of the Society of Hospital Medicine**

Source: Nelson Flores Hospital Medicine Consultants; Physician Executive Council interviews and analysis.
Once APs are working autonomously at top of license, there may still be an opportunity to improve hospitalist effectiveness by providing them with dedicated support for managing clinical logistics. This is especially true for complex patients who may require significant coordination and administrative management.

Our Lady of the Lake realized hospitalists could more effectively manage complex patients with multiple comorbidities if hospitalists had a partner who could provide basic clinical support. This level of support would be below license for an AP, but the right fit for an RN.

RNs have the clinical skills and knowledge to effectively manage medication reconciliation, but are also efficient at managing logistical details such as coordinating transportation at discharge, freeing up hospitalists to care for a greater number of patients.

### Seeking Clinical Logistic Support for Hospitalists at Our Lady of the Lake

<table>
<thead>
<tr>
<th>Hospitalist Program Support Needs</th>
<th>AP¹</th>
<th>RN</th>
<th>MA²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Patient Transportation</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

- Logistics below AP license standards
- RNs right mix of both clinical and logistic skills
- Clinical work above MA license standards

### Case in Brief: Our Lady of the Lake Regional Medical Center
- 750-bed hospital in Baton Rouge, Louisiana
- Growing hospitalist program needed increased clinical logistics support; tried APs, Medical Assistants, and combination but none right fit for program needs
- Hired RNs into hospitalist service to improve patient flow and provide top-of-license clinical logistic support

These specialized RNs at Our Lady of the Lake are hired directly into the hospitalist program, and receive specific training from hospitalists. They work with hospitalists in RN-hospitalist dyad teams, with each RN paired with a single hospitalist per shift. The team covers approximately 16 complex patients. Because the RN rotates out every three to four days, the hospitalist works with about two RNs per week-long shift.

The RN handles logistical and administrative details throughout the stay, such as completing paperwork for nursing home admission, and schedules follow-up appointments. They are also able to manage time-consuming medical tasks such as medication reconciliation for complex patients with a long, complicated medication history.

The RN and hospitalist do not always round together—the RN still works somewhat autonomously, and the pair is connected by phone. This allows them to work together when needed. For example, the hospitalist can call the nurse to come to the ED to work together on a new admission.

Each RN paired with one hospitalist
- Daily team census of ~16 patients
- RN rotates out every 3-4 days
- Hospitalist and RN do not always round together, but remain connected via phone

RNs hired into hospitalist program
- Report to a nursing supervisor, who reports to hospitalist director
- New hires receive two-month orientation to hospitalist service

RN Hospitalist Responsibilities
- Call in prescriptions, arrange transportation for discharge, and schedule follow-up appointments
- Handle paperwork, including forms for nursing home admissions, DME\(^1\) approval and PCP\(^2\) preferences
- Maintain admit/discharge patient census lists
- Assist with quality measures
- Work as “coordinator of the coordinators” by connecting the hospitalists’ plan with PCPs, chronic disease care clinics, insurers, specialists, home health providers, and nursing homes


\(^1\) Durable medical equipment.
\(^2\) Primary care physician.
Dedicated RN Support for Hospitalist Team Improves Outcomes

Our Lady of the Lake's use of RNs is proving to be a cost-effective mechanism to support hospitalists and improve quality. The model has led to a significant drop in both the hospital's readmissions and length of stay. Additionally, pairing RNs with hospitalists is significantly less expensive than pairing APs and hospitalists.

Organizations who want to adopt a similar model should ensure RNs understand the role before applying. An intensive training and onboarding process is also critical to success; RNs at Our Lady of the Lake go through two months of training and orientation before they are ready to be paired with a hospitalist.

Significant Improvement Evident at Our Lady of the Lake

Average National Salaries

<table>
<thead>
<tr>
<th></th>
<th>NP or PA</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>$105K</td>
<td></td>
<td>$69K</td>
</tr>
</tbody>
</table>

30-Day Readmission Rate at Our Lady of the Lake

<table>
<thead>
<tr>
<th></th>
<th>Louisiana</th>
<th>Our Lady of the Lake</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.6%</td>
<td></td>
<td>8.5%</td>
</tr>
</tbody>
</table>

1.6 Average LOS\(^1\) difference for patients with RN hospitalist nurses, compared to other medicine patients

The nurses are efficiency experts who improve flow by better coordinating existing resources...we have delivered in terms of ER throughput, decreased mortality and high levels of quality metric performance...[the RN hospitalist program has] certainly helped us.”

Richard Slataper, MD
Medical Director of the Hospital Medicine Service, Our Lady of the Lake

Optimizing Hospitalist Team Roles

To ensure hospitalist roles are optimized within your organization, consider these key questions about how hospitalists are used, and the opportunity to build supports that improve hospitalist effectiveness.

Key Questions for Physician Leaders

1. What is the current process for defining and reviewing hospitalist role and scope in our organization?

2. How do our hospitalists currently spend their time? Does our structure allow them to work effectively, at top of license, or are they spending time on low-value tasks? Do they have adequate clinical and administrative resources to be effective?

3. Do hospitalists have well-defined, targeted medical comanagement agreements that maximize hospitalist impact? Are these agreements focused on high-acuity patients?

4. Is there an opportunity to create specialized roles for hospitalists that support other service lines and improve overall quality for the hospital?

5. Are we deploying hospitalist advanced practitioners (NPs, PAs) effectively? Do their roles enable them to work at top of license?

6. Is there an opportunity to improve hospitalist efficiency by dedicating RNs to the program to help with clinical logistics?

Source: Physician Executive Council interviews and analysis.
Position Hospitalists for Quality Improvement

- Imperative 8: Institute shared prioritization for QI initiatives
- Imperative 9: Equip hospitalists to lead quality improvement initiatives
- Imperative 10: Hardwire connectivity between hospitalists and quality department
- Imperative 11: Explore implementing unit-based models to increase hospitalist accountability
Many hospitalists already support quality improvement initiatives. In fact, a 2013 survey found that nearly 60% of hospitalists nationwide report spending time on quality committees or working on specific quality initiatives. What is less clear is how often these efforts yield measurable results. Anecdotes from clinical leaders provide mixed reviews. In the literature, a meta-analysis of audit and feedback interventions (a common quality improvement intervention focused on auditing performance and educating providers to change practice) shows very limited results, with only 28% of QI initiatives reviewed yielding a 10% or greater improvement in the quality of care. This suggests that effective quality improvement interventions may require more complex change management.

Although hospitalists may be well-positioned to lead more complex quality improvement initiatives, they face several challenges to performance improvement, including burnout after multiple projects, insufficient training and mentorship, and limited connectivity to other providers that inhibits their ability to influence behavior.

### Common Challenges to Hospitalist-Led QI Initiative Success

#### Most Hospitalists Involved in QI, but Is It Working?

- **59%**
  - Hospitalists report spending time on committee work or quality initiatives

- **28%**
  - QI initiatives that result in 10% or greater improvement in quality of care

#### Three Challenges to Hospitalist-Led QI

1. **Hospitalists Overwhelmed with QI Initiatives**
   - Little buy-in for specific initiatives, or burnout after multiple quality improvement projects

2. **Hospitalists Not Properly Equipped to Lead or Work on Initiatives**
   - Lack necessary time, resources, training, and/or experience

3. **Attribution and Accountability**
   - Hospitalists’ unit-level influence over quality improvement often too diluted to produce consistent results

To equip hospitalists to succeed, hospitals must build a platform for hospitalist quality improvement efforts that addresses these challenges.

Executives can ensure hospitalists are aligned and engaged with the quality improvement agenda by establishing a shared prioritization process that considers hospitalist feedback and ideas for quality improvement.

Hospitalists must also be equipped with the resources and support needed to lead effective quality improvement work. This includes specific training and mentoring to lead complex quality improvement initiatives, and dedicated connectivity to expert support in the quality department.

Hospitalists also need greater, ongoing connectivity with other clinical teams. Executives should consider adopting unit-based models to enable hospitalists to partner more effectively with nursing and ancillary staff while taking on greater accountability for quality improvement results.

Must Address Gaps in Resources and Culture to Succeed

Four Imperatives to Position Hospitalists for QI Success

<table>
<thead>
<tr>
<th>Alignment and Engagement</th>
<th>Resources and Support</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imperative #8</td>
<td>Imperative #9</td>
<td>Imperative #11</td>
</tr>
<tr>
<td>Institute shared prioritization for QI initiatives</td>
<td>Equip hospitalists to lead quality improvement initiatives</td>
<td>Explore implementing unit-based models to increase hospitalist accountability</td>
</tr>
</tbody>
</table>

Hardwire connectivity between hospitalists and quality department

Need More Than Technical Support for Successful QI Initiatives

“QI work has to address both technical and adaptive issues…the science must be robust yet it must address values, beliefs, and attributes of the group involved…”

Peter J. Pronovost, MD
Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine

Many organizations fail to consider the hospitalist point of view when setting the quality improvement agenda. This is because hospital executives are often focused on strategic priorities while hospitalists are naturally more focused on the specific care delivery challenges they observe on a daily basis.

While organizations must prioritize interventions that are critical to organizational success, considering hospitalist input into the quality improvement process is a critical step that can prevent hospitalist disengagement and increase hospitalist buy-in for selected initiatives.

**Typical QI Prioritization Process Ignores Hospitalist-Identified Priorities**

<table>
<thead>
<tr>
<th>Hospital Executive Point of View</th>
<th>Hospitalist Point of View</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Focused on broader institutional strategy and priorities</td>
<td>• Focused on care delivery challenges observed on a daily basis</td>
</tr>
<tr>
<td>• May deprioritize hospitalist ideas due to limited or unmeasurable ROI</td>
<td>• Ideas not always aligned with institutional goals</td>
</tr>
</tbody>
</table>

**Example Priorities**

- **Reducing Care Variation**
- **Patient Satisfaction**
- **Improving ED Throughput**

**Example Priorities**

- **Improving Patient Handoffs**
- **EMR Enhancements**
- **Eliminating CAUTIs**

**Hospitalist QI Agenda for 2015**

1. Reducing care variation
2. Improving patient satisfaction
3. Improving ED throughput

Hospitalist QI priorities not resourced or supported, reducing hospitalist buy-in and support for their assigned QI agenda.
Rethinking Prioritization to Secure Engagement

Beador Hospital\(^1\) developed a QI initiative prioritization process that ensures hospitalist-identified improvement opportunities are considered.

Both hospital executives and hospitalists can submit potential ideas for quality improvement initiatives. The initiatives are then sorted based on the level of resource investment required.

High-resource initiatives are graded using a grid that assesses overall impact on institutional priorities, which ensures that resources are only deployed for projects that are strategically important.

Low-resource initiatives are scored based on their value to the hospitalist program, specifically, their ability to improve hospitalist efficiency or engagement.

This shared prioritization model means that all ideas have been considered, which improves hospitalist engagement. Additionally, it allows hospitalist leaders to more effectively communicate why a particular idea was approved.

### Beador Hospital\(^1\) Ensures Hospitalist-Identified Opportunities Considered

#### Beador’s QI Initiative Prioritization Process

<table>
<thead>
<tr>
<th>Opportunity Identification</th>
<th>Opportunity Submission</th>
<th>Prioritization Scoring</th>
<th>Resource Allocation Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital executives identify potential QI opportunities</td>
<td>QI opportunities sorted by level of resource investment required</td>
<td>High-resource investment track: Scored using grid that assesses ability to impact institutional priorities</td>
<td>Both hospitalist and hospital executive opportunities considered</td>
</tr>
<tr>
<td>Hospitalists identify potential QI opportunities</td>
<td></td>
<td>Low-resource investment track: Scored by hospitalist leader based on overall hospitalist program impact</td>
<td>Clear rationale for why initiatives are prioritized; facilitates enhanced communication</td>
</tr>
</tbody>
</table>

#### Case in Brief: Beador Hospital\(^1\)

- Large regional hospital in the Northeast
- Hospitalist leader developed a prioritization grid to score the quality improvement initiative support requests that require resources
- Smaller projects also consider hospitalist program impact, such as engagement and efficiency
- Limits total number of QI projects hospitalist team can pursue to prevent burnout while still allowing low-resource, high-hospitalist engagement projects

\(^1\) Pseudonym.

Source: Physician Executive Council interviews and analysis.
Prioritization Grid Clarifies QI Goals and Priorities

The key to an effective shared prioritization process is building a clear grid of organizational priorities. Beador Hospital’s grid has 15 criteria grouped into five sections aligned with institutional goals. Each criterion is given a score of zero to three points, with each score explicitly defined. The sum scores dictate which QI initiatives are prioritized.

The grid makes it easier for hospitalist leaders to communicate why hospitalist support for an initiative is so important to the organization, an important step to building buy-in for a particular initiative.

The difficult part of the process was getting hospital executives and hospitalist leaders to agree on the criteria for the grid. To accelerate the process for other organizations, the Physician Executive Council created a Hospitalist QI Initiative Prioritization Grid, pre-populated with suggested criteria for evaluating a quality improvement initiative. The grid can be downloaded from: advisory.com/pec/hospitalisttoolkit.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Score 3</th>
<th>Score 2</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Success</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact on Efficiency/Operating Costs</td>
<td>&gt;10% reduction in operating costs</td>
<td>1%-10% reduction in operating costs</td>
<td>No impact</td>
<td>Increase in staff or operating costs</td>
<td></td>
</tr>
<tr>
<td>Cost to Implement</td>
<td>No cost/Budget item</td>
<td>One time, &lt;5% of operating budget</td>
<td>One time, 5%-10% of operating budget</td>
<td>Ongoing increase in costs</td>
<td></td>
</tr>
</tbody>
</table>

Each initiative gets a score of zero to three on each criterion. QI initiatives with a total score of more than 28 are rolled out.

Excerpt of Beador’s1 QI Initiative Prioritization Grid

1) Pseudonym.
Hospitalists—who, nationwide, are generally a younger group of physicians—often lack the right training and experience to effectively lead quality improvement initiatives. 

In fact, a survey of hospitalists at an academic hospitalist meeting shows that all recognize they need more training in quality improvement. Additionally, nearly 70% of hospitalist leaders say their teams are lacking sufficient mentorship.

While it might be easy to arrange training and mentoring for hospitalists, building experience is more difficult. Ultimately, experience gaps can derail an effective quality improvement implementation.

The best way to equip hospitalists to overcome common roadblocks to quality improvement initiatives is to provide training and mentorship simultaneously. This allows hospitalists to put learning into practice immediately, while providing mentorship to overcome experience-based roadblocks such as change management.

Hospitalists Often Missing Skills, Experience to Lead Quality Improvement Efforts

Training and Mentorship Must Happen in Parallel

<table>
<thead>
<tr>
<th>Need Additional QI Training</th>
<th>Lacking Mentorship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalists Who Believe They Need More Training in Quality Improvement Skills</td>
<td>Hospitalist Leaders Who Agree That Lack of Mentorship Is a Major Issue for Their Hospitalist Group</td>
</tr>
<tr>
<td>n=40</td>
<td>n=111</td>
</tr>
</tbody>
</table>

100% 67%

Potential Roadblocks to QI Initiative Implementation

- Identify wrong QI problem
- Don’t know how to pick correct metrics
- Unable to draw correct conclusions from data
- Don’t achieve stakeholder buy-in
- Lack change management experience
- Incapable of effectively reporting on implementation progress

Northwestern Combines Classroom Training with Mentored Project Work

Northwestern recognized the need to combine didactic training with ongoing mentorship, and created the Academy for Quality and Safety Improvement. This academy combines classroom-based quality improvement training with ongoing quality improvement mentoring.

Participants must apply to the program with project ideas, which allows the organization to choose projects that are already likely to have stakeholder support.

Eleven classroom sessions teach hospitalists specific QI skills. Participants are also provided two mentors throughout, including one clinical expert and one quality improvement expert, to teach them how to implement change.

The steering committee ensures participants receive the support they need to succeed.

Initially, the program was created for hospitalists, but it has expanded to accept other interested physicians across the organization.

In exchange for the investment in this QI training and mentoring program, Northwestern is not only realizing quality improvement results, they are building a cadre of experienced quality improvement leaders.

Teaching the “What” and “How” of Quality Improvement

Classroom Sessions Solve QI Knowledge Gap, Project Mentoring Solves Experience Gap

11 Didactic Classroom Sessions
- Cover quality and measurement, data acquisition, data interpretation, leading change, and IT design for quality improvement
- Taught by Northwestern process improvement leaders

How to measure and analyze data

How to implement solutions and manage change

Six-Month Project Mentoring
- Clinical and QI mentors provided for each team
- Participants work in teams to develop and implement a QI project identified during application process
- Teams receive data collection and analysis support to implement intervention and measure results

AQSI¹ Steering Committee Ensures Buy-In, Resources

- Committee oversees application process and chooses quality improvement interventions
- Program directors ensure participant physicians have dedicated time to participate
- Process improvement and informatics leaders ensure EMR implementation and data support is available

Case in Brief: Northwestern University Feinberg School of Medicine

- Located in Chicago, Illinois
- In 2013, developed the Academy for Quality and Safety Improvement (AQSI), a seven-month professional development program designed to equip physicians with the knowledge and skills needed to effectively lead quality improvement initiatives
- 20 to 25 applicants are chosen for AQSI each year; participants attend classroom sessions and develop and complete a quality improvement project

¹) Academy for Quality and Safety Improvement.
Organizations interested in building quality improvement training and mentoring program should consider covering five essential topics, including how to identify and use performance data, quality improvement methods, best practices in change management, effective communications, and a review of organizational quality improvement resources available.

Additionally, while there may be a shortage of experienced hospitalist quality improvement mentors within the organization, novice hospitalists interested in quality improvement could effectively partner with more senior hospitalists leading a particular initiative. Hospitalists could also look to other non-hospitalist colleagues in the medical staff; for example, partnering with experienced infectious disease leaders on infection prevention initiatives.

### Considerations for Quality Improvement Training and Mentorship Programs

**Essential Topics for Hospitalist QI Training**

- Data acquisition and analysis
- QI methods (LEAN, Six Sigma, etc.)
- Change management
- Interdisciplinary teamwork and communication
- Overview of available QI resources/supports

**Options to Find Mentors for Hospitalist QI Projects**

- Pair new hospitalists with experienced hospitalists with similar QI interests
- Develop a QI mentoring program with formal action plans and regular mentor-mentee meetings
- Facilitate hospitalist networking to promote informal mentorships across other hospital executives and rest of medical staff
- Consider external hospitalist mentors available through the Society of Hospital Medicine’s Mentored Implementation Program


1) Quality Improvement.
Hospitalist teams and the quality department are often disconnected, leading to wasted effort from both groups. Working together, these groups can combine quality improvement efforts for greater effect.

For example, hospitalists are very good at identifying problems and potential solutions in care delivery, but they often lack the execution skills and experience to lead the work. Quality department leaders have significant project management experience, but may lack the practicing clinician perspective that could help them identify quality issues more rapidly.

To increase hospitalist and QI department connectivity, organizations should consider providing dedicated quality department support to the hospitalist team, and equipping the quality department with hospitalist-specific dashboards.

Hospitalists and Quality Department Have Different Expertise, Challenges

- **Hospitalists**
  - Good at finding problems and potential solutions
  - Lack project execution skills; do not know how to plan initiatives or connect to necessary resources

- **Quality Department**
  - Project execution experts; know how to plan QI initiatives and connect to appropriate support
  - Missing clinician perspective of most crucial gaps and opportunities

**Two Methods to Increase Hospitalist-Quality Department Connectivity**

1. Provide dedicated QI support
2. Use hospitalist-specific quality dashboards to build connectivity

Source: Physician Executive Council interviews and analysis.
Because of their exclusive inpatient focus, hospitalists often identify many quality improvement opportunities that other physician teams may not recognize. For example, a specialist may not see quality improvement gaps that hospitalists may encounter on a daily basis.

While hospitalists recognize many opportunities to improve care, they often lack connectivity to teams that can help resolve the quality gap. This was the case at Carilion Clinic, where the hospitalist leader noted that the team identified many improvement opportunities, but did not have a consistent way to connect to the quality improvement department for execution support.

**Hospitalists Identify Many QI Opportunities...**

- Complications
- Unnecessary Care
- Hospital-Acquired Conditions
- Resource Stewardship
- CAUTI Rates
- Care Pathway Standardization

...But Often Lack Support to Resolve

"Physicians are smart at seeing gaps in the system and coming up with ideas to make their work more logical. But a lot of QI projects fail because physicians lack project execution skills. They don’t know how to plan initiatives or connect to the right resources."

**Case in Brief: Carilion Clinic**

- Seven-hospital system based in Roanoke, Virginia
- One QI process engineer dedicated to 60-provider hospitalist program
- Hospitalists bring QI ideas to engineer, who meets weekly with Chief Hospitalist to prioritize projects and provide updates; QI engineer supports project needs and connects hospitalists to necessary resources and stakeholders
- Process engineer also creates hospitalist-specific tools

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1) Catheter-associated urinary tract infection.

Source: Carilion Clinic, Roanoke, VA; Physician Executive Council interviews and analysis.
Providing Hospitalists with a Dedicated Quality Department Resource

Carilion Clinic’s hospitalist leader worked to secure dedicated support from a QI process engineer. The engineer provides valuable support connecting hospitalists to resources for quality improvement across the organization, and monitors all of the hospitalist program’s quality improvement progress and results.

This engineer is still part of (and reports into) the quality department, but he has a dotted reporting line to the Chief Hospitalist. They meet three to four times per week to prioritize work and plan next steps for ongoing projects.

The QI process engineer acts as a regular sounding board for the hospitalist team, collecting their improvement ideas, and bringing them to the Chief Hospitalist for consideration on a regular basis. At their regular meetings, the process engineer and Chief Hospitalist decide which ideas will receive ongoing engineer support for implementation.

Lower-priority projects do not receive dedicated resources. However, the hospitalist who proposed the idea is connected to other stakeholders in the organization who can help implement a solution.

Carilion Process Engineer Connects Hospitalists to Expertise, Resources

Quality Improvement Project Expertise:
- Trained in quality improvement skill set
- Able to connect to appropriate resources and points of contact for project success
- Monitors projects’ progress and results

Dedicated to Hospitalist Program:
- Helps hospitalists execute on quality improvement ideas by filling gaps in project execution skills
- Dotted-line reporting to Chief Hospitalist; the two meet 3-4 times per week to prioritize potential projects and provide project updates

Hospitalist Project Prioritization
- Process engineer and Chief Hospitalist meet to prioritize hospitalist proposed ideas
- Prioritize projects based on quality improvement impact potential

Prioritized Projects Receive Ongoing Support
Engineer develops project plans and provides ongoing quality improvement expertise and support

Lower-Priority Projects Connected to Resources
Process engineer connects hospitalists to resources or relevant contacts, but does not remain involved

Source: Carilion Clinic, Roanoke, VA. Physician Executive Council interviews and analysis.
Connecting Hospitalists to the Right Resources

For example, while reviewing an adverse event in the ICU, a hospitalist realized the supply cart was missing an important supply that was sometimes, but not consistently, stocked in the cart.

Before the QI engineer was part of the hospitalist team, the hospitalist might have mentioned this concern at a team meeting, but it may not have been clear how to resolve the issue. Without access to the right nursing and supply leaders, it is possible nothing would have changed.

Instead, the hospitalist raised the concern to the team’s dedicated QI engineer. The issue was labeled low priority, which meant although it did not receive ongoing support from the QI engineer, the engineer connected the hospitalist to the right contacts in the supply and nursing departments who could help.

Enabling hospitalists to connect with the right resources has allowed them to take on even more substantial improvement projects, such as improving joint replacement insulin administration policies and reducing unnecessary imaging.

Other project examples include: Revising hip/knee replacement insulin administration policy; improving tracking of physician-generated delays in ED admissions orders; and reducing unnecessary imaging.

Source: Carilion Clinic, Roanoke, VA; Physician Executive Council interviews and analysis.
QI Resource Supports Next-Generation Improvements

In addition to helping hospitalists identify the right contacts to implement quality improvement changes, the process improvement engineer partners with the Chief Hospitalist on the high-priority quality improvement opportunities. As an example, the team recently worked together to combine disparate data streams to build a hospitalist dashboard focused on resource utilization.

The dashboard helps hospitalists compare their resource utilization to peers. A small group of hospitalists are piloting the dashboard to vet it and build broader buy-in.

This dashboard is another example of how connecting the hospitalist program with the QI department can enable greater results than if either went it alone—the Chief Hospitalist likely would not have had the time or resources to build this kind of dashboard, and the QI engineer would struggle to secure buy-in from the hospitalists.

In this case, providing the Carilion hospitalist team with a dedicated QI resource allowed them to complete more quality improvement projects and work towards more difficult, high-priority resource utilization goals.

Carilion QI EngineerDevelops Hospitalist Resource Utilization Dashboard

Sample Resource Utilization Dashboard

Compared costs of each individual hospitalist to those at the 25th, 50th, and 75th percentiles.

Source: Carilion Clinic, Roanoke, VA; Physician Executive Council interviews and analysis.
Another way to connect hospitalists to quality improvement support is with the use of a hospitalist-specific performance dashboard. Sunrise Hospital used hospitalist-specific dashboards to enable greater connectivity between hospitalists and the quality team.

The Clinical Transformation Manager, (CTM), at Sunrise used a hospitalist dashboard to identify opportunities for improvement, and then as a way to collaborate with hospitalist leaders.

Instead of simply giving performance data to the hospitalists, she asked questions to understand the variation in performance.

She then tailored her approach to that specific need. For example, she did group training to improve coding for one hospitalist group. She also provided direct coaching for one hospitalist who needed to learn how to more effectively manage the daily patient census.

The dashboards allow for ongoing connectivity, but the greater value is the collaboration that ensues as a result of reviewing the performance data.

Performance Improvement Process at Sunrise Hospital

<table>
<thead>
<tr>
<th>Problem Identification</th>
<th>Targeted Root Cause Analysis</th>
<th>Customized Support</th>
<th>Ongoing Connectivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTM uses hospitalist-specific scorecards to identify quality opportunity</td>
<td>Discusses scorecards with low-performing hospitalists to understand root causes</td>
<td>CTM develops tailored training and individual coaching based on root cause problems identified</td>
<td>Provides regular quality updates at monthly hospitalist meetings</td>
</tr>
</tbody>
</table>

Case in Brief: Sunrise Hospital and Medical Center

- 690-bed hospital in Las Vegas, Nevada; part of HCA’s 8-hospital Far West Division
- Hospitalist service comprised of several small groups and independent providers
- First Clinical Transformation Manager (CTM), an RN by training, hired in November 2013
- Crimson analysis focused CTM on hospitalists; CTM developed hospitalist performance scorecards, educated hospitalists, and shared scorecard performance data
- 1,662 inpatient days saved across 15 hospitalists in two groups for a combined $831K in CMI1-Adjusted ALOS2 savings from September to December 2014

Scorecards Support Greater Collaboration

The data shows physicians where there are opportunities to improve, but it doesn’t tell them how…I am helping them understand where and how they can improve their performance.”

Joanne Orlando, RN
Clinical Transformation Manager
Sunrise Hospital and Medical Center

1) Clinical transformation manager
2) Average Length of Stay
3) Case-mix index

Source: Sunrise Hospital and Medical Center, Las Vegas, NV; Physician Executive Council interviews and analysis.
The hospitalist dashboards support collaboration at two levels: with hospitalist group leaders and with individual hospitalists.

The group-level dashboards allow the Clinical Transformation Manager (CTM) to identify areas where groups are underperforming. The data is used to ask questions rather than as a punitive tool. Initially, hospitalists could view all of the data in a blinded format, but as the group became more trusting of the data and how it was used, they opted to make group comparisons visible. This makes it possible for the CTM to quickly identify and resolve quality variation between groups.

The individual-level dashboards allow both the CTM and the hospitalist leaders to identify potential outliers within their team. Again, this allows the CTM to target resources where they are needed most.

Excerpts of Hospitalist Performance Dashboard at Sunrise

Sunrise Hospital’s Facility-Level Hospitalist Dashboard

Excerpt of Individual Hospitalist-Level Dashboard

Individual hospitalist dashboard supports targeted one-on-one coaching

Dashboards identify outlier hospitalist groups and metrics to examine
Since introducing the dashboards, the hospitalist program at Sunrise has realized significant quality improvement results.

For example, the average length of stay for two hospitalist groups dropped significantly, yielding significant cost savings.

**Targeted Approach Enables Significant Improvements**

**Targeted Approach Improves Average Length of Stay, Standardization**

**Sunrise Average Length of Stay**

- **May-August**: 6.38
- **September-December**: 6.55

ALOS not only reduced, but is now more consistent across hospitalist groups.

**Four-Month Hospitalist Impact**

- **Total days saved**: 1,662
- **CMI²-adjusted ALOS cost savings**: $831K

1) Across 15 hospitalists in two groups.
2) Case mix index.

Source: Sunrise Hospital and Medical Center, Las Vegas, NV; Physician Executive Council Interviews and analysis.
Data from high-reliability industries suggests that teams with staff that have not consistently worked together are more prone to accidents. The National Transportation Safety Board analyzed all of the aircraft incidents and found new teams were riskier: 73% of incidents occurred on the crew’s first day working together, and 44% of incidents happened on their first flight together.

Hospitalists are often deployed in ways that force them to work with a new team every day, and often new teams within a single shift. This makes it difficult for hospitalists to build familiarity and collaborate with staff. Without social capital, hospitalists are poorly positioned to drive change.

However, this problem is not a new one. Many organizations are focused on implementing strategies to improve communication and increase social capital between hospitalists and other members of the care team.

### Hard to Lead QI Initiatives Without Familiarity, Social Capital

#### Airline Incidents Linked to Unfamiliar Teams

- **73%**
  - Percentage of airline incidents that occurred on a cockpit crew’s first day of working together

- **44%**
  - Percentage of airline incidents that occurred on a cockpit crew’s first flight together

#### Unit A Team
- 7:00 AM
  - Caring for patients on Unit A

#### Unit B Team
- 8:00 AM
  - Caring for patients on Unit B

#### Unit C Team
- 9:00 AM
  - Caring for patients on Unit C

#### Unit D Team
- 10:00 AM
  - Caring for patients on Unit D

Two Ways to Increase Hospitalist Team Connectivity

Two commonly implemented strategies for improving communications between hospitalists and other members of the care team are multidisciplinary rounding and unit-based (or geographic) staffing.

Multidisciplinary rounds bring most, if not all, of the care team together in the same room at the same time to discuss patient care.

Another way to improve connectivity is by adopting a unit-based or geographic staffing model for hospitalists. This model assigns hospitalists to provide care for all or most of the patients in a specific geographic area within the hospital. Because hospitalists are working in one area, nursing and ancillary staff are more consistent across the shift, which improves the ease of communication and can also increase social capital and familiarity across the team.

Though neither idea is new, there is increased interest in unit-based models because they have been shown to increase productivity by reducing the amount of time hospitalists spend walking between floors and units.

Both Improve Communication; Unit-Based Staffing Adds Efficiency

Comparing Multidisciplinary Rounding and Unit-Based Staffing

**Multidisciplinary Rounding**

**What is it?**

Hospitalists, nurses, ancillary clinicians meet together at the same time to plan patient care

**Pros:**

• Increases connectivity and collaboration between hospitalists and different care teams
• Can reduce errors and length of stay

**Cons:**

• Requires dedicated time and leadership to execute effectively
• Takes more time than traditional rounds; coordinating schedules across units often difficult

**Unit-Based (Geographic) Staffing**

**What is it?**

Hospitalists assigned to patients based on specific geographic location

**Pros:**

• Improves hospitalist familiarity and collaboration with the care team on that unit
• Increases hospitalist efficiency by reducing travel time between units

**Cons:**

• Bed assignment slowed when hospitalist-staffed units are full
• May result in unbalanced hospitalist workload or less diverse patient mix

Source: Physician Executive Council interviews and analysis.
Unit-Based Staffing Appealing but Difficult to Implement

Interest in unit-based staffing is high, but organizations cite many challenges in making the model sustainable.

A research poster at the 2015 Society of Hospital Medicine annual meeting illustrates this challenge—it is titled, “5th Time’s a Charm” and discusses the requirements that must be in place to effectively implement this model. It underscores the need to establish and maintain a broad base of stakeholder support.

Therefore, organizations who hope to adopt a unit-based staffing model for their hospitalists must begin by defining institutional needs and priorities, and implementing a model that focuses on those specific goals.

Once the model is in place, leaders must continue to adjust the model to maintain executive stakeholder support, making compromises where needed to reduce conflicts or improve performance.

Despite Interest in Model, Many Hospitals Struggling to Adopt

Lessons Learned from Repeated Attempts to Implement Unit-Based Model

“Creation of unit-based care teams is feasible…but requires engagement of hospital leadership, various stakeholders…and alignment with other institutional goals…”

Key Steps to Successful Implementation of Unit-Based Model

1. Define institutional priorities and customize the model to meet specific stakeholder needs
2. Establish and maintain stakeholder support by balancing compromise with potential benefits

Unit-Based Model Targets Top Stakeholder Priorities

St. Francis Hospital in Hartford, Connecticut, successfully implemented a unit-based hospitalist staffing model by first identifying institutional needs, and then adjusting the model to ensure it met those needs.

Goals for the unit-based model included reducing patient handoffs, improving resource allocation, and reducing quality improvement fatigue.

To reduce patient handoffs, a coordinated, consistent hospitalist and nursing team was deployed to each unit for several weeks at a time. This allowed patients to keep the same team across their stay.

To improve resource allocation, the pilot unit was designed to focus on complex patients, allowing the unit to direct additional support and staffing to a single geographic area.

The unit structure also reduced quality improvement fatigue, as leaders were able to target specific interventions to specific units based on performance. This lowered the total number of initiatives any unit must implement.

St. Francis also developed a “20 minute rule” to accelerate the assignment of complex patients when throughput issues are a concern. This compromise helped to maintain broad buy-in for the model.

Key Components of St. Francis’s Unit-Based Model Pilot

- **More Consistent, Connected Teams**
  - *Decreases patient handoffs, improves coordination*
  - Consistent hospitalist and nursing teams conduct regular multidisciplinary rounds; incorporate patient and family feedback
  - Hospitalists may rotate between units after 8-week assignment; 80% geographic-based location allows for some variation

- **Patients Assigned Based on Complexity**
  - *Improves resource allocation*
  - Patients assigned to unit based on LACE score embedded in EMR
  - Bed assignment staff trained to wait 20 minutes for appropriate bed; after 20 minutes, assigned based on capacity

- **Unit-Level Dyad Leadership**
  - *Increased hospitalist ownership over quality reduces QI fatigue*
  - Hospitalist unit-leader paired with nurse leader for each unit
  - Unit-level leaders receive dedicated time to oversee quality initiatives in unit

**Case in Brief: St. Francis Hospital and Medical Center**

- 550-bed hospital located in Hartford, Connecticut
- Initiated a six-month pilot to assign five hospitalists geographically to one 30-bed unit; patients in unit assigned based on acuity using LACE score
- After six months, readmission rate dropped by 22% and LOS dropped by 10%; direct cost decreased
- Two additional units transitioned to model in first year; four more planned in second year (80% localization)
- Unit-based hospitalist model enables targeted quality improvement, recent initiative reduced CAUTI rates by 49% in six months

---

1) The LACE index identifies patients that are at risk for readmission within 30 days of discharge. It incorporates four parameters: “L” stands for the length of stay of the index admission, “A” stands for the acuity of the admission, “C” stands for co-morbidities, “E” stands for the number of Emergency Department visits within the last six months.
2) Length of Stay.
3) Catheter Associated Urinary Tract Infection.

Source: St. Francis Hospital and Medical Center; Hartford, CT; Physician Executive Council interviews and analysis.
Pilot Secures Broader Buy-In for the Model

Results from the initial pilot not only allowed leaders to maintain support for the unit, but to also secure executive backing to expand the model to other units.

In a six-month period, 30-day readmission rates in the pilot unit dropped 22% and length of stay dropped 10%. Additionally, hospitalist and nursing engagement increased.

After the initial pilot, St. Francis expanded the model to two other units in the same year. They plan to transition four more units in the second year, resulting in 80% geographic assignment of medicine patients.

Pilot Results Build Support for Model Beyond Executive Team

Planned Phases of Broader Hospital Rollout

1 successful pilot unit

2 more units transitioned in first year

Goal of transitioning additional 4 units in second year

Pilot Enables Expanded Hospitalist Team Buy-In

“At the end of six months, hospitalists said that if this were the model of care, then they would never think of leaving hospitalist practice. They felt as if they were coming to work in an office setting of a 30-bed unit…The model was received extremely well.”

Surendra Khera, MD
CMO, Saint Francis Hospital and Medical Center

Source: St. Francis Hospital and Medical Center, Hartford, CT; Physician Executive Council interviews and analysis.
Two Components of Increased Hospitalist Accountability

The unit-based model enables hospitalists to have more ownership over unit performance. The hospitalist-nurse dyad creates a local leadership structure that is accountable for unit performance. The leaders have dedicated administrative time to oversee quality improvement efforts in the unit. This unit-based staffing model also allows for more meaningful performance reporting and attribution. Instead of the potential pushback due to attribution concerns, reports allow teams to understand the impact of their quality initiatives and allow for rapid pilot testing within a unit.

Unit Structure Allows for Leadership, Performance Improvement Attribution

Unit-Level Leadership

- Hospitalist-nurse dyad creates “local” leadership for unit teams; report into higher-level physician-nurse dyads
- Dedicated point of contact for improvement initiatives
- Dedicated administrative time to oversee unit’s quality performance
- Unit leaders meet as a committee to share challenges; best-practice dissemination

Unit-Level Performance Reporting

CAUTI1 rate improvement on track to significantly surpass FY15 goal

Streamlined dashboards communicate performance to unit team and create urgency

QUALITY AND SAFETY DASHBOARD-UNIT 7-2

<table>
<thead>
<tr>
<th>Desired Direction</th>
<th>FY14</th>
<th>FY15 Goal</th>
<th>FY15 YTD</th>
<th>Performance Compare</th>
</tr>
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<tbody>
<tr>
<td><strong>Quality and Safety</strong></td>
<td></td>
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<tr>
<td>CAUTI Rate per 1000 Foley Days</td>
<td>↓</td>
<td>5.6</td>
<td>4.9</td>
<td>2.5</td>
</tr>
<tr>
<td>Falls per 1000 Patient Days</td>
<td>↓</td>
<td>2.6</td>
<td>2.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Falls with Injury per 1000 Patient Days</td>
<td>↓</td>
<td>1.13</td>
<td>1.05</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Process and Efficiency</strong></td>
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<td></td>
<td></td>
</tr>
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<td>ED Boarding Time</td>
<td>↓</td>
<td>223</td>
<td>201</td>
<td>238</td>
</tr>
<tr>
<td>Acute Care LOS</td>
<td>↓</td>
<td>4.12</td>
<td>4.05</td>
<td>3.8</td>
</tr>
<tr>
<td>VTE-1: VTE Prophylaxis</td>
<td>↑</td>
<td>92.1</td>
<td>94.1</td>
<td>82.1</td>
</tr>
</tbody>
</table>

1) Catheter-associated urinary tract infection.

Source: St. Francis Hospital and Medical Center, Hartford, CT; Physician Executive Council interviews and analysis.
Accountability Enables Focused Quality Improvement

The increased accountability of the unit-based model supports targeted, rapid quality improvement. For example, St. Francis produced a significant reduction in CAUTI rates.

The CMO compared unit-to-unit performance and targeted those with the highest CAUTI rates. The CMO reached out directly to the leaders of these units to better understand the root cause of the low performance, and how to resolve it. In this case, units with high CAUTI rates needed targeted education to understand how to prevent UTI infections.

This focused approach to training led to big results, as the CAUTI rate dropped by nearly 50%, and in April 2015, they had the first CAUTI-free month in hospital history.

### Three Steps to Major CAUTI Reduction

1. **Target Specific Units**
   - CMO compares unit-level CAUTI rate data
   - Output: Produces list of units with high CAUTI rates

2. **CMO Partners with Unit Directors**
   - Unit directors root-cause specific CAUTI challenges
   - Output: Identifies resources and training needed to lower CAUTI rates

3. **Implement Unit Training**
   - Targeted educational program for lowest-performing units
   - Output: Addresses specific challenges described by unit directors

### Targeted Program Produces Results

- **49%** Reduction in CAUTI rates in targeted units over six-month period
- **May 2015** First CAUTI-free month in hospital’s history

---

1) Catheter-associated urinary tract infection.

Source: St. Francis Hospital and Medical Center, Hartford, CT; Physician Executive Council interviews and analysis.
Overcoming Common Stakeholder Challenges to Unit-Based Model

Unit-based models can position hospitalists to improve quality across the hospital, but achieving stakeholder buy-in for implementation is difficult.

Some examples of common stakeholder concerns are a lack of patient variety, an unbalanced workload, and throughput or bed assignment bottlenecks.

Bed assignment staff may be concerned that the unit-based models will slow ED throughput, as blocking units for specific patients can make it harder for find a bed once the decision to admit is made.

The counterpoint is that these units can reduce overall length of stay and readmissions, both of which can help reduce capacity constraints over time. Potential adopters might consider a 20-minute rule (or some other time interval), as St. Francis did, to limit the overall impact on throughput.

### Matching Stakeholder Concerns to Potential Solutions

<table>
<thead>
<tr>
<th>Stakeholder Concern</th>
<th>Why It’s a Concern</th>
<th>Potential Compromise or Selling Point</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalist Concern:</strong> Lack of patient variety/mix</td>
<td>Hospitalists enjoy seeing a variety of clinical conditions and complexities</td>
<td>Rotating hospitalists between units every three months ensures ability to treat a variety of patients</td>
</tr>
<tr>
<td><strong>Hospitalist Concern:</strong> Unbalanced workload</td>
<td>Hospitalists staffed to high-acuity unit have longer to-do lists to manage patients</td>
<td>Having all complex patients in the same unit makes it easier to standardize care and direct additional support resources</td>
</tr>
<tr>
<td><strong>Administrator Concern:</strong> Throughput bottleneck</td>
<td>“Blocking” unit capacity for the right patient can mean slower admission times; requires more thoughtful bed allocation process</td>
<td>Model can reduce capacity strain in the long term by reducing length of stay and complications; establishing “wait time caps” limits the amount of time a bed assignment can be delayed</td>
</tr>
</tbody>
</table>

Source: St. Francis Hospital and Medical Center, Hartford, CT; Physician Executive Council interviews and analysis.
Consider these questions to identify opportunities to better position hospitalists for quality improvement within your organization.

### Key Questions for Physician Leaders

1. Do we have an established process for prioritizing hospitalist participation in quality improvement initiatives? Do we allow hospitalists to provide input into the prioritization process?

2. Have we equipped hospitalists with the resources to successfully lead quality improvement initiatives, including dedicated time, training, and mentoring?

3. Does the hospitalist program have regular connectivity with the quality department/quality improvement team?

4. Have we considered implementing unit-based hospitalist staffing models to improve collaboration and increase hospitalist accountability at the unit-level for quality?

5. If considering a unit-based hospitalist staffing model, have we customized the model in such a way to target high-level institutional needs and achieve stakeholder support?
Establish Role in Accountable Care

- Imperative 12: Establish hospitalist connectivity with strategically important SNFs
- Imperative 13: Consider deploying hospitalists to transitional care clinics
As organizations enter into more risk-based payment contracts, they become accountable for episodic, or even total, costs. For four high-volume DRGs—joint replacement, stroke, pneumonia and urinary tract infection—the highest costs within the episode occur after the initial hospitalization.

Hospitalists can help reign in this unnecessary spending while simultaneously improving care in the post-acute care space. Positioning hospitalists in this capacity will require expanding their traditional role to include managing patients in the post-acute setting.

Potential to Lower Costs by Focusing on Post-Discharge Care

**Medicare Claims for 30-Day Episodes Beginning with Hospitalization**

<table>
<thead>
<tr>
<th>DRG 470: Major Joint Replacement without MCC</th>
<th>DRG 065: Intracranial Hemmorage or Cerebral Infarction with CC</th>
<th>DRG 194: Simple Pneumonia and Pleurisy with CC</th>
<th>DRG 690: Kidney and Urinary Tract Infections without MCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>$9,593</td>
<td>$21,822</td>
<td>$7,072</td>
<td>$8,727</td>
</tr>
<tr>
<td>$11,079</td>
<td>$6,392</td>
<td>$5,347</td>
<td>$3,989</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Acute Stay</th>
<th>Post-Discharge Care</th>
</tr>
</thead>
</table>

**Traditional versus Expanded Hospitalist Role**

**Traditional Hospitalist Role:**
- Inpatient care and discharge planning
- Inpatient care and inpatient initiatives
- Discharge summaries and PCP notification
- Ensuring follow-up appointments scheduled prior to discharge

**Expanded Hospitalist Role:**
- Managing post-acute patients
- Managing patients after discharge into the following settings:
  - Inpatient rehabilitation facility
  - Long-term acute care hospital (LTACH)
  - Skilled nursing facility
  - Post-discharge clinics

Evaluating Post-Acute Expansion of Hospitalists

Ultimately, an organization’s level of payment risk dictates the need to expand the role of the hospitalist beyond the acute setting.

Organizations in predominantly fee-for-service models should focus investments on penalty avoidance, for example, focusing on reducing readmissions penalties.

Organizations with some payment risk should consider investing in care models that reduce costs across the episode. This includes establishing partnerships with strategically important skilled nursing facilities to improve quality.

Organizations responsible for total cost of care may also want to consider more comprehensive transitional care models that ultimately reduce total inpatient volume.

Identify Degree of Payment Risk First

Hospitalist Focus Dependent On Level of Payment Risk

<table>
<thead>
<tr>
<th>Fee-for-Service Payment</th>
<th>Mixed Payment Risk</th>
<th>Risk-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding P4P(^1) readmissions penalties by focusing on improved discharge planning while in the inpatient setting</td>
<td>Avoiding payment penalties and reducing inpatient volume for certain patient groups</td>
<td>Reducing total cost of care across entire episode, including redirecting patients to non-inpatient settings</td>
</tr>
</tbody>
</table>

Imperative #12
Establish hospitalist connectivity with strategically important SNFs\(^2\)

Imperative #13
Consider deploying hospitalists to transitional care clinics

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\(^1\) Pay-for-performance.  
\(^2\) Skilled Nursing Facility.

Source: Physician Executive Council interviews and analysis.
Nearly a quarter of all Medicare patients are discharged to a SNF after hospitalization. SNF quality is highly variable as illustrated by their wide range in readmissions rates. Given that an estimated 50% of SNF readmissions are potentially avoidable, there is significant potential to improve quality by partnering with SNFs.

Hospitals can compare their SNF readmissions rates to similar hospitals using the Hospital Benchmark Generator, available on advisory.com.

**Advisory Board Tool in Brief: The Hospital Benchmark Generator**
Shows your organization’s SNF readmissions rate compared to national or custom cohorts.

**Risk-Adjusted Readmissions Rates from SNFs Variable**

- **22%** Medicare patients discharged to a SNF after hospitalization
- **50%** SNF readmissions that are potentially avoidable

75th Percentile Performance

25th Percentile Performance

Just as the term “hospitalist” applies to physicians who work primarily in the inpatient setting, the term "SNFist" refers to physicians—either independent or hospital-affiliated—who primarily practice in SNFs.

There are two models for deploying hospitalists to SNFs. In a full-time SNFist model, hospitalists spend their day in the SNF, and focus entirely on post-acute patients. Hybrid SNFist models—which allow hospitalists to split their time between the acute care hospital and the SNF—are optimal for facilities that are close enough to allow for regular care team meetings or that can connect to the hospital's EMR.

Hospitalists are increasingly playing a role in improving SNF quality. Nearly 20% of hospital leaders surveyed in 2015 said they are deploying hospitalists to SNFs in some capacity.

### Two SNFist Deployment Models

#### Full-Time SNFist Model
*Hospitalist practices entirely in SNF(s)*

**Considerations:**
- Ideal for hospitalists interested in providing post-acute care (many hospitalists often want to keep exclusive acute focus)
- Full-time SNFists better equipped to change overall facility quality

#### Hybrid Hospitalist/SNFist Model
*Hospitalist splits time between hospital and SNF(s)*

**Considerations:**
- Relies on proximity or IT connectivity between hospital and SNF to improve coordination
- Best for facilities where number of SNF patients doesn’t require full-time coverage

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**Source:** Post-Acute Care Collaborative, PAC-Hospital Clinician Partnerships, Washington, DC; The Advisory Board Company, 2013; Physician Executive Council April 2015 Hospitalist Program Survey, Physician Executive Council interviews and analysis.

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SNFists Improve Care Quality, Value for ACO

Advocate Health—a 13-hospital system based in Chicago—has a robust ACO covering over 700,000 lives and uses a full-time SNFist model to ensure patients receive high-quality care in SNFs after they are discharged.

Advocate SNFist teams are comprised of a full-time SNFist and three APs, and help reduce cost across the entire episode. These teams serve 37 SNFs with the highest volume of Advocate ACO patients. At the start of partnering with a SNF, both parties sign a letter of agreement confirming their expectations for quality, and focus on reducing both hospital readmissions and SNF length of stay. Advocate’s SNFist teams also provide ongoing quality training for facility staff on topics such as infection control protocols.

Full-Time SNFists at Advocate Health

Advocate SNFist Team

- Each team includes one full-time SNFist physician and three APs
- Teams serve 37 SNFs with highest volume of Advocate ACO referrals

Key Objectives of Advocate’s SNFist Team Model

1. **Align Quality Metrics**
   - Advocate and partner SNFs sign letter of agreement outlining quality and performance expectations upon adoption of model

2. **Reduce Hospital Readmissions**
   - SNFist teams elevate SNF clinical capabilities and conduct individual case reviews to reduce unnecessary hospitalizations

3. **Ensure Appropriate SNF Length of Stay**
   - SNFist teams play active role in managing patients’ care plans and improving efficiency

4. **Provide Ongoing Quality Training**
   - SNFist team members serve as highly qualified resources for staff and provide ongoing training (for example, on infection control protocols)

Case in Brief: Advocate Health System

- 13-hospital health system based in Chicago, Illinois, with robust Accountable Care Organization (ACO); covers over 700,000 lives in some type of risk-based contract
- Developed SNFist-Advanced Practitioner (AP) teams to monitor care and improve outcomes by rounding in 37 SNFs with high Advocate ACO referrals in order to minimize ACO’s risk
- SNFists are either independent or Advocate-employed, but all are members of Advocate Physician Partners ACO; most APs are Advocate-employed
- SNFist-AP teams focused on decreasing length of stay and readmission rates; program reduced readmission rates from 24% to 14%, and average SNF length of stay to 14 days, compared to the market average of 30 days

1) Advanced Practitioners; the 1:3 ratio is an average and can vary based on average SNF acuity, distance between SNFs, etc.

Source: Advocate Health System, Chicago, IL; Post-Acute Care Collaborative, Understanding Trends in SNF Medicare Volumes, The Advisory Board Company, 2013; Physician Executive Council interviews and analysis.
The partnership between affiliated SNFs and Advocate benefits both parties.

This model helped Advocate lower the total cost of care for its patient population by reducing readmissions by 42% and lowering SNF length of stay by 16 days, resulting in $42 million of savings per 10,000 lives covered by the ACO.

The SNFs also benefitted from a secure place in Advocate’s ACO network because of their improved quality.

Benefits Outweigh Cost Due to Sufficient Risk-Based Payment Contracts

**SNF Benefits**

- Enhanced care quality and capabilities with SNFist oversight and training
- Secured place in Advocate’s network through improved ability to support partner’s needs

**Advocate Benefits**

- Reduced costs of care by decreasing hospital readmissions and SNF length of stay
- Secured strong post-acute partners minimize full episode risk

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**Advocate’s SNFist Model Produces Significant Results**

- **42%** Reduction in readmission rates
- **16** Days below market SNF length of stay average
- **$42M** In savings per ACO patient panel of 10,000 patients in 2013-2014

A Word of Caution: Must Equip Hospitalists to Work Optimally in SNFs

It is important to note that hospitalists need additional education and training to be effective in the SNFist role.

IPC Healthcare, a national hospitalist practice company, recognized the volume of hospitalist interactions occurring in SNFs was growing rapidly. To address the need, they created a training module to help hospitalists understand how to work effectively in the SNF setting.

The training module is available to other hospitalists through the Society of Hospital Medicine Learning Portal, and focuses on topics including correct documentation in the SNF setting, common post-acute patient challenges, and how to work effectively in the post-acute setting.

As SNF Demand Grows, IPC Healthcare Recognizes Training Need

IPC Patient Interactions Occurring in SNFs

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2010</td>
<td>4%</td>
</tr>
<tr>
<td>2014</td>
<td>30%</td>
</tr>
</tbody>
</table>

Different Skill Sets Needed

- **3-5 days**
  - Acute care ALOS\(^1\)
- **23 days**
  - SNF ALOS

> Post-acute staffing is much less rote. The secret sauce for hospitalists is learning how to take care of these patients longitudinally.”

Jerry Wilborn, MD, FCCP
National Medical Director for PAC Services
IPC Healthcare, Inc.

Case in Brief: IPC Healthcare, Inc.
- 2,300-provider national hospitalist practice company based in North Hollywood, California
- IPC developed CME\(^2\) module for hospitalists transitioning from acute to post-acute care
- SHM\(^3\) used IPC's module as a template for its “Primer for Hospitalists on SNFs”

Tool in Brief: SHM Primer for Hospitalists in Skilled Nursing Facilities
- Online educational program developed between the Society of Hospital Medicine and IPC Healthcare, Inc.
- Targeted to experienced acute care hospitalists who need to learn about patient care in the SNF setting
- Available to SHM member and non-members for a fee on [shmlearningportal.org](http://shmlearningportal.org)

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1) Average length of stay.
2) Continuing medical education.
3) Society of Hospital Medicine.

Source: IPC Healthcare, Inc., North Hollywood, CA; Society of Hospital Medicine, Primer for Hospitalists on Skilled Nursing Facilities, SHM Learning Portal, [https://www.shmlearningportal.org/Activity/3400032/Detail.aspx](https://www.shmlearningportal.org/Activity/3400032/Detail.aspx); Physician Executive Council interviews and analyses.
Assessing the Need for Transitional Care Clinics

Transitional care clinics are another way to improve the quality of care provided across the episode. Before deploying hospitalists to a transitional care clinic, organizations must have a specific goal in mind, based on the organization’s degree of payment risk.

For example, organizations that are still predominantly fee-for-service should consider post-discharge clinics focused on improving timely follow-up to reduce 30-day readmissions. If the organization is subject to a readmissions penalty, the investment in the post-discharge clinic may reduce the impact of the penalty, making the investment worthwhile.

Organizations with substantial payment risk for the entire cost of a population should consider a more comprehensive model such as an extensivist clinics. These comprehensive clinics not only prevent readmissions, they also focus on reducing the total cost of care by improving the medical management of complex patients, in many cases, avoiding hospitalizations altogether.

Level of Payment Risk Defines Goal for Transitional Clinic

Source: Physician Executive Council interviews and analysis.
Beth Israel Deaconess Medical Center’s hospitalists found it was often incredibly difficult, if not impossible, to schedule a follow-up visit within seven days for patients from the hospital’s affiliated PCP practice. Because follow-up within seven days of discharge is highly correlated with readmissions rates, the hospitalist team worked to set up a post-discharge clinic, staffed by hospitalists, to manage patients unable to get a follow-up visit in time.

**Case in Brief: Beth Israel Deaconess Medical Center (BIDMC)**
- 649-bed academic medical center in Boston, Massachusetts
- Healthcare Associates (HCA, a large affiliated primary care group in the area) worked with BIDMC hospitalist program to establish a post-discharge clinic
- Post-discharge clinic staffed by hospitalists open for five, four-hour sessions per week; four dedicated hospitalists rotate staffing the clinic in month-long shifts
- Primary care access issues resolved over six years; post-discharge clinic closed in August 2015

**PCPs Initially Unable to Address Urgent Follow-Up Needs**

Waiting 10 minutes on hold to speak to a scheduler, only to hear that the first available appointment was in three weeks, easily disrupted my busy days as a hospitalist.”

Lauren Doctoroff, MD
Post-Discharge Clinic Leader
Beth Israel Deaconess Medical Center

**PCP Follow-Up Often Delayed**

Hospitalists call PCP offices, but timely appointments often unavailable

Clinic Ensures Patient Access to Post-Discharge Follow-Up Within Seven Days

The hospitalist team defined an explicit set of processes to ensure the clinic’s resources were targeted effectively.

The clinic was open to patients of the hospital’s affiliated primary care practice who were discharged from either the hospital or the ED. Only patients who were unable to schedule a follow-up with their PCP within one to two weeks of discharge could schedule an appointment at the post-discharge clinic.

The clinic is staffed by hospitalists and is open for five sessions (each four hours) per week. Dedicated hospitalists rotate staffing the clinic in month-long shifts.

### Two Sources of Post-Discharge Clinic Patients

**Patients Discharged from the Hospital**
- Appointments scheduled by dedicated inpatient service, using scheduling rule

**Patients Discharged from the ED**
- Often scheduled via a nurse outreach phone call within 48 hours of an ED visit
- Patients can also make their own post-discharge clinic appointments after an ED visit

### Post-Discharge Clinic Scheduling Process

1. **Patient discharged**
2. **PCP appointment within 1-2 weeks**
3. **PCP unavailable within 1-2 weeks**
4. **Post-discharge clinic appointment scheduled within one week**

Clinic’s Narrow Scope Effectively Targets Readmissions

In addition to targeting specific patients, the clinic focused exclusively on the patient’s condition that led to the ED visit or hospital stay. Hospitalists staffing the clinic didn’t treat unrelated chronic care issues, or provide other preventative care.

BIDMC’s access improvement results are shown on the right—post-discharge patients were seen eight days earlier than before, and the likelihood of being seen within one week of discharge increased by 40%.

Notably, in 2015, the medical center closed the clinic because the affiliated primary care group was able to enhance access and provide more timely post-discharge appointments.

For some organizations, setting up a post-discharge clinic can be a temporary stopgap for avoiding readmissions penalties until local primary care providers are structured to provide greater access.

However, a post-discharge clinic focused only on immediate discharge follow-up may be insufficient for organizations with more complex patient management problems that will not be solved simply by expanding access.

Post-Discharge Clinic Does Not Provide Comprehensive Care

BIDMC’s Post-Discharge Clinic Visit Focuses on Hospitalization Follow-Up

- Reason for hospitalization
- Review of symptoms
- Medication reconciliation
- Outstanding test assessment
- Key follow-up with PCP and specialists
- Chronic outpatient issues
- Other preventative care

Clinic Improves Timely Access

8.45
Days earlier that post-discharge clinic patients are seen vs. other patients post-discharge

40%
Increased likelihood that patients will be seen within a week of discharge

The Longstreet Clinic, a large, independent, multispecialty group in Georgia, needed to better manage their most complex patients as they adopted shared savings contracts.

They not only faced increased demand for same-day and after-hours primary care access from complex patients, they were also now accountable when these complex patients presented in the ED.

At the same time, several tenured hospitalists expressed dissatisfaction with the direction of the inpatient hospitalist program, and wanted to provide care for complex, acute patients in a different setting.

At Longstreet, Opportunity to Improve Management of High-Risk Patients

Three Factors Driving Demand for Extensivist Clinic at The Longstreet Clinic

- **Access Gaps**: Increased demand for same-day and after-hours primary care access
- **Increased Payment Risk**: Two shared savings contracts and two Medicare Advantage contracts led to increased focus on most complex patients
- **Provider Disengagement**: Several tenured hospitalists professionally dissatisfied with direction of hospitalist program, but still wanted to provide high-acuity care

### Case in Brief: The Longstreet Clinic

- 164-provider independent multispecialty group based in Gainesville, Georgia
- Recently moved six hospitalists out of the hospital setting to staff extended-hours outpatient clinic, called the Comprehensive Care Program (CCP)
- CCP offers high-acuity patient care services to the medically fragile, among other services

Source: The Longstreet Clinic, Gainesville, GA; Physician Practice Roundtable; Physician Executive Council interviews and analysis.
To address these challenges, Longstreet designed an extensivist clinic—their Comprehensive Care Program.

The extensivist clinic is staffed by two experienced hospitalists who are supported by two NPs. Hospitalists work a typical, seven-on-seven-off schedule, and have the skills and experience to care for very sick patients. Hospitalist staffing is critical as PCPs focused primarily on outpatient care may lack the time and experience with acute patients to care for a similar population.

This clinic provides an expanded set of services, including immediate access to infusion, imaging, labs, and pharmacy in order to prevent hospitalizations.

The clinic is located in Longstreet’s main outpatient facility, and across the street from the hospital ED. This makes it easy for Longstreet’s PCPs to refer patients to the clinic instead of sending them to the ED, and if the patient is deemed too ill for outpatient care they can quickly be transferred to the hospital.

Expanding Hospitalists’ Role at The Longstreet Clinic

**Longstreet’s Comprehensive Care Program (CCP)**

**Staffed by Hospitalists**
- Six hospitalists and two NPs
- Hospitalists work 7 on/7 off schedule

**Services**
- Intensive management for medically complex patients
- Post-discharge care
- Urgent care
- Access to outpatient imaging, laboratory, pharmacy, and infusion

**Location**
- Located in Longstreet Clinic’s main outpatient facility
- Located across the street from hospital ED

**Rationale**
- High-acuity skill set; can manage diverse mix of high-risk patients
- Have hospital privileges; able to follow high-risk patients to inpatient setting
- Hospitalists used to 7 on/7 off schedule
- Variety of services support medical management of complex patients
- Goals to prevent unnecessary hospitalizations and reduce total cost of care, as well as improve continuity and transitions of care
- Can easily draw upon equipment and staff from within main facility
- Patients admitted directly to hospital, avoiding the emergency department
- Developing perioperative program for surgical patients

Source: The Longstreet Clinic, Gainesville, GA; Physician Practice Roundtable; Physician Executive Council interviews and analysis.
The diagram at right illustrates how Longstreet’s extensivist clinic model (the Comprehensive Care Program) prevents hospital admissions.

In this example, an 84-year-old patient with a recurrent urinary tract infection might typically be sent to the hospital when the infection doesn’t respond to antibiotics. The patient could spend up to 25 days in the hospital, after a lengthy stay followed by a readmission.

Longstreet’s extensivist clinic often avoids the entire inpatient admission. First, the PCP refers the patient to the clinic upstairs instead of to the hospital. The clinic gets quick lab results that indicate the UTI is resistant to oral antibiotics, and the patient is then seen daily in the clinic for antibiotic injections. After the infection clears, the patient is referred to a house-call service and is sent back to her PCP for ongoing management, completely avoiding the hospital admission.

Example Patient: 84-year-old with recurrent UTI

Traditional Process versus CCP for Example Patient

Traditional Process

- Admitted for recurrent UTI (LOS: 20 days)
- Readmission within 30 days (LOS: 5 days)
- Total IP stay: 25 days

CCP Care Plan

- Culture results indicate UTI resistant to oral antibiotics
- Patient presents to PCP; referred to CCP for possible IV treatment
- Patient seen daily in CCP for 7 days for evaluation, daily injections of Rocephin
- Total IP stay: 0 days

Example Patient: 84-year-old with recurrent UTI

Source: The Longstreet Clinic, Gainesville, GA; Physician Practice Roundtable; Physician Executive Council interviews and analysis.

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The extensivist clinic is a significant investment that is providing strong returns for Longstreet. Early results show they are meeting shared savings goals, and their PCPs and specialists are very satisfied with the model. They were also able to retain and keep their valuable, experienced hospitalists highly engaged.

Longstreet’s Comprehensive Care Program is already breaking even and helping the group capture greater market share. Approximately 15% of clinic patients are new patients to the group.

Part of the reason for the clinic’s success is the use of experienced hospitalists who are comfortable managing complex patients in the clinic setting.

### Program’s Success Evident in Multiple Measures

#### Three Measures of Program’s Success

- **Increased Capacity to Meet Shared Savings Goals**
  Anecdotal evidence shows CCP\(^1\) enhances group’s ability to meet shared savings goals

- **Heightened Referring Provider Satisfaction**
  CCP improved engagement across Longstreet’s PCPs and specialists

- **Retaining Experienced Hospitalists**
  Alternative role for hospitalists considering other career paths; preserves clinical expertise

#### New Program Seeing Strong Early Returns

- **4** Months of operation after which CCP hit patient visit breakeven goal\(^2\)
- **15%** Percentage of new patients visiting CCP
- **10,487** Patient visits to CCP between January and August 2015

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\(^1\) Comprehensive Care Program.
\(^2\) Longstreet’s goal breakeven point was 46 patients per day; by month four they were seeing 49 patients per day.

Source: The Longstreet Clinic, Gainesville, GA; Physician Practice Roundtable; Physician Executive Council interviews and analysis.
Establishing Hospitalist Role in Accountable Care

Listed at right are key questions for organizations considering expanding the role of hospitalists beyond the acute setting.

Key Questions and Considerations for Physician Leaders

1. Do we have a strong understanding of what high-volume PCPs need to improve discharge communication?

2. What are our goals for focusing on care of discharged patients in the post-acute space? Are we seeking only to minimize readmissions penalties, or are we also focused on driving down total cost?

3. How is our hospital readmissions rate for patients coming back from SNFs? Are there any high-volume, low-performing SNFs we should prioritize for partnership?

4. What kind of EMR connectivity do we have with post-acute facilities in our market? If connectivity is low, is there another way to ensure SNF access to inpatient records?

5. What is our goal for a potential transitional care clinic? Do we want to just reduce hospital readmissions, or also reduce total admissions and hospital volume overall?

6. If billing alone does not cover transitional care clinic costs, can we afford the investment? Is there an opportunity to offset the cost with penalty avoidance or shared savings?

7. If considering a more comprehensive extensivist clinic, do we have access to hospitalists interested and capable of managing highly complex patients in an outpatient setting?

8. Do we have a strategy to address PCP concerns about a potential transitional clinic? How will PCPs and other providers view this change?
To help physician executives and their team, the Physician Executive Council developed the Hospitalist Program Improvement Toolkit. The toolkit includes implementation resources to execute the concepts profiled within this publication.

**Hospitalist Program Improvement Toolkit**

**Leverage to Capture Greater ROI from Your Hospitalist Program**

**Resources in the Hospitalist Program Improvement Toolkit**
Available online at [advisory.com/pec/hospitalisttoolkit](https://advisory.com/pec/hospitalisttoolkit)

1. **Realign Hospitalists with Hospital Priorities**
   - Hospitalist Program Gap Assessment
   - Hospitalist Program Improvement Plan

2. **Optimize Hospitalist Role**
   - Meeting Guide: Optimizing Hospitalist Clinical Scope
   - Hospitalist Role Red Flag Audit
   - Special Report: Specialist-Hospitalists

3. **Position Hospitalists for Quality Improvement**
   - Quality Improvement Prioritization Grid
   - Accountable Care Unit™ archived webconference
   - Hospitalist Financial Impact Estimator

4. **Establish Role in Accountable Care**
   - SNFist Role Research Brief

Source: Physician Executive Council interviews and analysis.
Hospitalist program improvement

Best for:
Chief medical officers and hospitalist leaders

What’s next?

Now that you’ve learned 13 imperatives for capturing the full value of the hospitalist program, use our Hospitalist Program Improvement Toolkit to implement change within your organization.

Hospitalist Program Improvement Toolkit
- Hospitalist Program Gap Assessment
- Hospitalist Program Improvement Plan
- Meeting Guide: Optimizing Clinical Scope
- Hospitalist Role Red Flag Audit
- Hospitalist Financial Impact Estimator
- Quality Improvement Prioritization Grid

Learn more at advisory.com/pec

Learn how to:
- Realign hospitalist program priorities to health system needs (p. 32)
- Refine clinical comanagement agreements to maximize hospitalist value (p. 45)
- Learn how to optimally deploy hospitalists in transitional care post-discharge (p. 97)

Reading time: 90 min.

Best for:
Chief medical officers and hospitalist leaders
Capturing the Full Value of the Hospitalist Program

Imperatives for improving hospitalist program ROI

Look inside for:
- Strategies for expanding hospitalist program value
- Guidance for driving hospitalist program improvement
- Physician leader’s checklist for optimizing hospitalist role