Strategies to Realign and Optimize Your Hospitalist Team—and Boost ROI

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Road Map

1. A Scalable Force for Quality Improvement
   - Realign Hospitalists to Hospital Priorities

2.  

3.  
   - Optimize Hospitalist Role
Hospitalists Firmly Established in Our Organizations

Greater Numbers of Hospitals Using Hospitalists

Percentage of US Hospitals with Hospitalist Service

- 29% in 2003
- 55% in 2008
- 70% in 2013

95% of 200+ bed hospitals use hospitalists

Source: AHA Hospital Statistics; Physician Executive Council interviews and analysis.
Represent a Scalable Force for Quality Goals

Hospitalists an Inflection Point for Value-Based Payment Metrics

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

n=74 CMOs and hospitalist leaders

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

¹ Value-based purchasing.

Source: Physician Executive Council April 2015 Hospitalist Program Survey; Pay-for-Performance Assessment, Data and Analytics Group, The Advisory Board Company; Physician Executive Council interviews and analysis.
Significant Investment Occurring in Hospitalist Program

Professional Fees Rarely Cover Full Cost of Hospitalist Resources

Median Financial Support Received per FTE Hospitalist Physician
n=499 hospital medicine groups

- 2012: $139,090
- 2014: $156,063 (12.5% increase)

89%
Percentage of adult hospital medicine groups receiving financial and/or other support in addition to professional fees

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.
Defining Hospitalist Performance Too Narrowly

Many Organizations Only Considering Operational Costs and Benefits

Most Common Forms of Financial Subsidy for Hospital or Health-System Employed Groups¹

n=138 hospital medicine groups

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Absorption of Practice Operating Losses</td>
<td>74%</td>
</tr>
<tr>
<td>In-kind services</td>
<td>22%</td>
</tr>
<tr>
<td>Fixed, predetermined amount</td>
<td>18%</td>
</tr>
<tr>
<td>Variable incentive based on performance</td>
<td>18%</td>
</tr>
<tr>
<td>Variable payment based on workload or volume</td>
<td>12%</td>
</tr>
<tr>
<td>Variable payment based on number of hospitalist FTEs</td>
<td>4%</td>
</tr>
</tbody>
</table>

¹ Adult-only hospital medicine groups who identified as owned or employed by the hospital, health system, or integrated delivery system. Respondents could indicate more than one type of financial support, so lines will not add to 100%.

More Than A Cost Center

“I’m on the hook because they cost too much, and everyone wants to minimize the financial loss…unfortunately, our tendency is to think about the hospitalist service line as a cost center, not about how they can benefit the system.”

Chief Medical Officer
Health System in the West

Missing 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

Organizational Value

Time

Source: Physician Executive Council interviews and analysis.
Four Challenges to Realizing Greater Hospitalist Value

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.
Capturing the Full Value of the Hospitalist Program

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 provider 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

Today’s Presentation

Thursday, June 23rd

Source: Physician Executive Council interviews and analysis.
Capturing the Full Value of the Hospitalist Program

Download or Order Publication Today

- Includes:
  1. Strategies for expanding hospitalist program value
  2. Guidance for driving hospitalist program improvement
  3. Physician leader’s checklist for optimizing hospitalist role

Download or order a copy today at advisory.com/pec/hospitalisttoolkit
1. A Scalable Force for Quality Improvement

2. Realign Hospitalists to Hospital Priorities

3. Optimize Hospitalist Role
Variety of Hospitalist Group Structures

Hospitalist Employment Model, Program Maturity Varies

Percentage of Hospital Medicine Groups by Employment Model
n=499 hospital medicine groups

- Hospital, health system, or university: 60%
- Multi-state hospitalist management company: 27%
- Private medical group: 10%
- Other: 3%

Hospital Medicine Groups’ Years in Existence
n=482 hospital medicine groups

- 15+ years: 34%
- 10–14.9 years: 22%
- 5–9.9 years: 33%
- 1–4.9 years: 18%

1) Respondents answered either “Private multi-specialty or primary care medical group” or “Private local/regional hospitalist-only group.”
2) Respondents answered either “Hospital, health system, or integrated delivery system” or “University, medical school, or faculty practice plan.”

Source: Society of Hospital Medicine 2014 State of Hospital Medicine Report; Physician Executive Council interviews and analysis.

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Hospitalist Employment No Guarantee of Alignment

Employment of Hospitalists on the Rise

Percentage Hospitalist Groups Directly Employed by a Hospital or Health System

- 23% in 1998
- 34% in 2006
- 50% in 2014

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

Often Difficult to Establish Shared Hospitalist Identity

Multiple Hospitalist Groups within a Facility is a Challenge

Percentage of Hospitalist Programs with More than One Hospitalist Group
n=71

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

Source: Physician Executive Council April 2015 Hospitalist Program Survey; Physician Executive Council interviews and analysis.
Building a Foundation For Alignment

Three Common Challenges to Aligning Hospital and Hospitalist Priorities

- **Variable performance between multiple hospitalist groups limits standardization and collaboration**
  - **Imperative #1:** Set minimum standards to reduce performance variability between hospitalist groups

- **No shared view of hospitalist program potential or the resources needed to improve**
  - **Imperative #2:** Assess gaps between hospitalist program and hospital priorities to reset alignment

- **Inconsistent connectivity and collaboration between hospitalists and hospital executives**
  - **Imperative #3:** Position hospitalist leaders to maintain alignment

Source: Physician Executive Council interviews and analysis.
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 A has no incentive to maintain strong performance

<table>
<thead>
<tr>
<th>Group</th>
<th>Readmission Rate</th>
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<tbody>
<tr>
<td>A</td>
<td>4%</td>
</tr>
<tr>
<td>B</td>
<td>18%</td>
</tr>
<tr>
<td>C</td>
<td>10%</td>
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</tbody>
</table>

Group B views target as impossible and ignores incentive

Target of 8%

Hospitalist Group Variability Common

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

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.
Addressing Variable Hospitalist Group Performance

Building Consensus for Greater Standardization at Houston Methodist Hospital

- Quality dashboard highlights hospitalist group performance outliers
- Performance too variable between groups to set shared goals for facility
- Limited collaboration across various hospitalist groups

Retreat Focused on Certification Criteria
- Hospitalist leaders from each group attend; agenda focuses on creating certification criteria
- Workgroups established minimum standards for hospitalist certification
- Establishes collaboration across hospitalist groups for improving performance metrics

1) Medical Executive Committee.

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

**Criteria Set by Hospitalist Group Leaders Reduces Variation**

#### Houston Methodist Hospitalist Group Certification Criteria

**Group Size**
- ✓ Minimum of five hospitalists per certified group

**Coverage Criteria**
- ✓ Provide 24/7 coverage with 30-minute in-hospital availability

**Practice Criteria**
- ✓ Round prior to 11:00 am on patients anticipated to be discharged that day

**Performance Metrics**
- ✓ Participate in hospital’s quality incentive program that provides $30,000 quality bonus for success

**Group Leader Requirements**
- ✓ Conducts monthly review of group metrics and overall performance
- ✓ Represent group on Hospitalist Governance Council

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**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

Source: Houston Methodist Hospital, Houston, TX; Physician Executive Council interview and analysis.
Certification Facilitates Consolidation and Alignment

Hospitalist Groups at Houston Methodist

<table>
<thead>
<tr>
<th>Before Certification Process</th>
<th>After Certification Process</th>
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<tbody>
<tr>
<td>16</td>
<td>6</td>
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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

Source: Houston Methodist Hospital, Houston, TX; Physician Executive Council interview and analysis.
Health System Merger Highlights Hospitalist Variation

Variation across Facilities within a Health System

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 ~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

Discharges per FTE Hospitalist

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<th>E</th>
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<td></td>
<td>41</td>
<td>22</td>
<td>18</td>
<td>32</td>
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Risk-Adjusted Readmissions Index

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<th>Hospitals</th>
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<tr>
<td></td>
<td>1.41</td>
<td>1.03</td>
<td>0.81</td>
<td>1.12</td>
<td>1.05</td>
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</tbody>
</table>

Difficult to standardize goals across facilities with performance variability across the system

Source: Mount Sinai Health System, New York, NY; Physician Executive Council interview and analysis
Determining the Cause of Performance Variation

System Hospitalist Leader Analyzes Structural Variation First

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 / Outcomes
- Resource Utilization

Cataloging Underlying Hospitalist Program Differences

Assessment of structural differences causing variation between facilities, including:

- Average patient census and CMI\(^1\)
- 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

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.

1) Case-mix index.
Reaping Benefits of Cross-Facility Standardization

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.
Initially Missing System-Level Priorities at Carolinas Hospitalist Group

Hospitalist Group Unaware of Larger Health System Priorities

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

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

Health system executive leadership still questions hospitalist program value

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

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

Carolinas’ Visioning Session

Assess Current Perceptions

Leaders separately discuss 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

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

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.
Developing a Playbook to Achieve Shared Vision

Carolinas’ Hospitalist Management Action Plan

<table>
<thead>
<tr>
<th>Hospitalist Management Action Plan Themes</th>
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<tbody>
<tr>
<td>1</td>
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<td>6</td>
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<td>7</td>
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For each theme, action plan specifies:

**Action Item**
Lists a specific goal as well as granular steps that must be completed (example: “conduct 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.
Establishing a Shared View of Hospitalist Program

Introducing the Hospitalist Program Gap Assessment

Excerpt from the Hospitalist Program Gap Assessment Tool

<table>
<thead>
<tr>
<th>Hospitalist Program Gap Assessment</th>
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<tbody>
<tr>
<td><strong>Results</strong></td>
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</tbody>
</table>

| The hospitalist program is aligned with the hospital and/or health system. | 3.00 |
| The hospitalist program takes a thoughtful and rational approach to its scope of clinical activities. | 2.00 |
| The hospitalist program plays a leadership role in addressing key clinical issues in the hospital and/or health system: teaching, quality, safety, efficiency and the patient/family experience. | 2.50 |
| The hospitalist program actively works to support care coordination across care settings. | 3.00 |

**Results from Part II: Assessing Program Resources and Supports**

| The hospitalist program has effective leadership. | 1.87 |
| The hospitalist program has an effective planning and management infrastructure. | 2.67 |
| The hospitalist program has adequate staffing and administrative support. | 3.06 |
| The hospitalist program has engaged hospitalists. | 1.00 |
| The hospitalist program recruits and retains qualified clinicians. | 2.67 |

**Suggested Next Steps**

1) Fill out your name at the top and print this results sheet, save, and print. (This page is formatted for printing on 8.5 x 11 paper.) Ask other physician executives and hospitalist leaders at your organization to take this assessment and print their results.

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 build a shared view of program gaps and resources
- Based on SHM Key Characteristics and Principles of an Effective Hospital Medicine Group, a tool refined over three years by top hospitalist leaders and tested by 26 groups nationwide
- Downloaded the tool from advisory.com/pec/hospitalisttoolkit

Source: Society of Hospital Medicine, *The Key Principles and Characteristics of an Effective Hospital Medicine Group* 2015, available www.hospitalmedicine.org/KeyChar; Physician Executive Council interview and analysis.
Disconnected Leaders With Different Priorities

3. Position hospitalist leaders to maintain alignment

Difficult to Define and Balance Competing Needs

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

55%  Lack direct accountability over hospitalist program

30%  Disagree hospitalist leaders effectively balance hospitalist and organizational needs

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\(^1\) CMO, CMIO, CQO, CCO, VPMA respondents; n = 33.

Source: Physician Executive Council April 2015 Hospitalist Program Survey; Physician Executive Council interviews and analysis.
Connecting Hospitalists, Facility and System Leaders

Carolinas Hospitalist Group Site Leaders Maintain Alignment

Site Hospitalist Leadership Structure

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

- Site Leaders Positioned as Partner, Not Vendor
  Collaborate with facility leaders on program need, but ultimately report to system hospitalist leadership

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

- Supported by Hospitalist Operating Committee
  Site leaders meet weekly with other site leaders and system leaders to share challenges, discuss system needs

Key Elements of Site Hospitalist Leader Role:

1. Site Leaders Have Dedicated Administrative Time
2. Site Leaders Positioned as Partner, Not Vendor
3. Balanced Autonomy and Accountability
4. Supported by Hospitalist Operating Committee

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.
System-Wide Structure Ensures Site Alignment

**System Reporting Structure Ensures Alignment Across Hospitalist Group**

- **System-wide Program Director**
  - Regional Lead
    - Regional Lead
      - Site Leaders
      - Site Leaders

*70% administrative time*

**Operating Committee Structure Helps Site Hospitalist Leaders Balance Competing Needs**

- Facility CMO requests new type of hospitalist support, 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

*50% administrative time*

All site leaders serve on CHG¹ Operating Committee

*20% administrative time*

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¹ Carolinas Hospitalist Group.

Source: Carolinas Hospitalist Group, Charlotte, NC; Physician Executive Council interview and analysis.
Realign Hospitalists with Hospital Priorities

Key Questions for Physician Executives

• 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?

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

• 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?

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

• 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?

• Have we positioned our hospitalist leaders in roles that balance competing stakeholder needs?
1. A Scalable Force for Quality Improvement

2. Realign Hospitalists to Hospital Priorities

3. Optimize Hospitalist Role
The Quest for the Perfect Number of Hospitalists

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

- Patient population
- Hospitalist training and experience, support available
- Shift length
- Etc.

Right Number of Hospitalists Depends on Role

Failing to Use Hospitalists Effectively Wastes Limited Resource

Time-Study Shows Hospitalists Spending Limited Time with Patients

n=24 hospitalists across 494 hours

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>EMR</td>
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</tr>
<tr>
<td>Non-patient Communication</td>
<td>26%</td>
</tr>
<tr>
<td>Direct patient care</td>
<td>17%</td>
</tr>
<tr>
<td>Other indirect care</td>
<td>16%</td>
</tr>
<tr>
<td>Professional Development</td>
<td>7%</td>
</tr>
</tbody>
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Spending Time on Low-Value Work

“I’m working so far below my license I can’t even see it anymore.”

Hospitalist Leader
Southwestern Health System

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 Accelerating Evolution of Hospitalist Role and Scope

- Increased specialist demand for hospitalist consults
  - Imperative #4: Refine medical comanagement model to maximize hospitalist impact

- Specialists less involved in leading or establishing care protocols
  - Imperative #5: Evaluate opportunities to develop specialized roles for hospitalists

- Growing use of non-physician support to increase hospitalist capacity
  - Imperative #6: Ensure ROI from advanced provider hospitalist roles
  - Imperative #7: Weigh dedicated RN support to increase hospitalist efficiency

Source: Physician Executive Council interviews and analysis.
Variable Returns from Medical Comanagement

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

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”
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 stretched thin and lack proper bandwidth to target high-acuity patients

Hospitalists write pre-op notes, even for low- and medium-acuity patients

Only added value is surgeon convenience; hospitalists feel frustrated, underutilized
Targeting High-Risk Patients for Comanagement

Mount Sinai’s Four-Step Approach to 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, COPD(^1), 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 Disease.

**Updated Agreement Produces Significant Results**

**Mount Sinai’s Vascular Surgery Results Pre- and Post-Comanagement Agreement**

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

“"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

Source: The Mount Sinai Hospital, New York, NY; Physician Executive Council interviews and analysis.
Focus on Key Elements of Comanagement Success

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, 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.

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Limited Standardization Impacts Hospital, Hospitalists

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
- PEAC reduced complications and cancellations and increased care pathway standardization

Orthopedic Surgical Variation at Middlesex Hospital

Each surgeon follows different care protocols for similar surgeries, patients

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

- High surgery cancellation rate, inefficiency
- Inconsistent adherence to P4P measures
- High complication rate penalizes hospital

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

1) Advanced Practitioner.
2) Pay-for-performance.
Defining the Perioperative Hospitalist Role

Two Responsibilities of Middlesex’s Perioperative Hospitalist Role

1. Develops standardized protocols that maximizes hospitalist, AP\(^1\) roles

2. Educates hospitalists on perioperative management, protocols

Orthopedists\(^2\)  Perioperative Hospitalist  Other Hospitalists

Completes pre-op assessments (H&P\(^3\), risk assessment) formerly done by hospitalists

Perioperative Hospitalist Role

- Full-time role; works 7am-3pm 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.

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1) Advanced practitioner.
2) 14 orthopedic surgeons in three different groups.
3) History and physical.
Benefiting From Perioperative Hospitalist Role

Benefits from Middlesex’s Perioperative Hospitalist Program

- **Drops in complications, 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.
Evaluating Specialized Hospitalist Roles

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

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

   **DRG\(^1\) 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 and 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 skillset 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

---

\(^1\) Diagnosis-related group.

Source: Physician Executive Council interviews and analysis.

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6. Ensure ROI from advanced provider hospitalist roles

**Use of Hospitalist Advanced Practitioners Rising**

But Often Struggling To Use Them Effectively

**Hospitalist Groups Using Advanced Practitioners (APs)**

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

n=409; 2014 data

**Common Challenges to Using APs within the Hospitalist Program**

1. **Setting Appropriate Scope**
   - APs’ limited diagnostic skillset limits full autonomy, but creating top-of-license roles is difficult

2. **Right-Sizing Physician Oversight**
   - APs’ skills and experience variable, making it difficult to standardize physician oversight

3. **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).


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Four Key Characteristics of Optimized AP Roles

Key Characteristics of Successful Hospitalist AP Roles

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

Examples of High-Value Hospitalist AP Roles

- Observation unit
- Disease-specific consult services:
  - Psychiatric
  - Heart failure
  - Diabetes
- Disease-specific protocolized units:
  - Bone marrow transplant unit

Source: Parekh VI, Roy CL, "Nonphysician Providers in Hospital Medicine: Not So Fast", Journal of Hospital Medicine Vol 5 No 2 February 2010; Physician Executive Council interviews and analysis.
Finding the Right Fit for Hospitalist APs

Sacred Heart Tries Nurse Practitioners in Variety of Roles

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

Evolving Use of Hospitalist NPs over Three Years

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

Source: Sacred Heart Medical Center, Spokane, WA; Physician Executive Council interviews and analysis.
Narrow NP\textsuperscript{1} Roles Reduce Turnover, Improve Outcomes

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

**KEY ELEMENTS**

- **NPs receive role-specific training from either DM\textsuperscript{2} hospitalist or psychiatric NPs**
- **NPs managed directly by hospitalist team**
- **NPs care for approximately 14-20 patients, including new consults**

**BENEFITS**

- **Improved NP satisfaction, reduced turnover since implementation**
- **Improved quality and reduced infection rate for complex surgical diabetes patients\textsuperscript{3}**
- **Able to keep psychiatric patients in psychiatric ward, regardless of comorbidities**

---

1) Nurse Practitioner.
2) Diabetes Management.
3) Reduced infection rate observed in open-heart and vascular surgery patients after DM-NP role implemented.

Source: Sacred Heart Medical Center, Spokane, WA; Physician Executive Council interviews and analysis.
A Simple Analysis for Confirming AP Value

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

“90-95% 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
Co-Founder and Past President of the Society of Hospital Medicine

Source: Nelson Flores Hospital Medicine Consultants; Physician Executive Council interviews and analysis.
7. Weigh dedicated RN support to increase hospitalist efficiency

Trying to Find Top-of-License Support

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


¹) Advanced Practitioner.  
²) Medical Assistant.
RN Right Fit for Hospitalist Clinical Support

RN-Hospitalist Dyad Team at Our Lady of the Lake Regional Medical Center

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

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, 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

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


1) Durable medical equipment.
2) Primary care physician.
Hospitalist RNs Improving Outcomes

Average National Salaries

NP\textsuperscript{1} or PA\textsuperscript{2} | RN
--- | ---
$105K | $69K

30-Day Readmission Rate at Our Lady of the Lake

Louisiana | Our Lady of the Lake
--- | ---
15.6% | 8.5%

-1.6
Average LOS\textsuperscript{1} difference for patients with RN hospitalist nurses, compared to other medicine patients

“\textbf{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.”

\textit{Richard Slataper, MD}

Medical Director of the Hospital Medicine Service, Our Lady of the Lake

---

\textsuperscript{1} Nurse Practitioner.
\textsuperscript{2} Physician Assistant.
3) Length of stay.

Optimize Hospitalist Role

Key Questions for Physician Leaders

- What is the current process for defining and reviewing the hospitalist role and scope in our organization?
- 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?
- Do hospitalists have well-defined, targeted medical comanagement agreements that maximize hospitalist impact? Are these agreements focused on high-acuity patients?
- Is there an opportunity to create specialized roles for hospitalists that support other service lines and improve overall quality for the hospital?
- Are we deploying hospitalist advanced providers (NPs, PAs) effectively? Do their roles enable them to work at top-of-license?
- Is there an opportunity to improve hospitalist efficiency by dedicating RNs to the program in order to help with clinical logistics?
- Have we assessed our need for specialist-hospitalists?
# Hospitalist Program Improvement Toolkit

Leverage to Capture Greater ROI from Your Hospitalist Program

## Resources in the Physician Executive Council’s Hospitalist Program Improvement Toolkit

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Realign Hospitalists with Hospital Priorities</strong></td>
<td><strong>Optimize Hospitalist Role</strong></td>
<td><strong>Position Hospitalists for Quality Improvement</strong></td>
<td><strong>Establish Role in Accountable Care</strong></td>
</tr>
</tbody>
</table>

- Hospitalist Program Gap Assessment
- Hospitalist Program Improvement Plan Template
- Meeting Guide: Optimizing Hospitalist Clinical Scope
- Hospitalist Role Red Flag Audit
- Special Report: Specialist-Hospitalists
- Quality Improvement Prioritization Grid
- Accountable Care Unit™ archived webconference
- Hospitalist Value Calculator
- Research Brief: Exploring SNFist Models

[advisory.com/pec/hospitalisttoolkit](advisory.com/pec/hospitalisttoolkit)

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Source: Physician Executive Council interviews and analysis.