Hospital medicine has been a significant part of the US health care landscape for a little more than two decades—the blink of an eye in American medical history. In that short time, however, hospital medicine practitioners—now known as hospitalists—have established themselves as important players in the nation’s health care system. To understand the rise of hospitalists, it is necessary to appreciate the vast changes that have occurred in health care over the past 25 years—chiefly that the denominator of care has shifted from quantity to quality (now called “value-based care”).

This transition has posed many challenges to medical institutions. For example, it means that “value” now equals patient outcome per dollar spent—which is a mandate of the Affordable Care Act (ACA). Of the stakeholders interested in getting hospital care to patients—including outpatient doctors, surgeons, nurses, and hospital administrators—hospitalists have proved themselves essential to ensuring that dollars are spent wisely in achieving best outcomes. Consequently, they have become central to medical institutions’ ability to meet the reimbursement requirements of Medicare and the ACA. As Dahlia Rizk, DO, Chief of the Section of Hospital Medicine at Beth Israel Medical Center, put it, "every expense is now scrutinized and redundancies won’t be tolerated [by reimbursers].”

There are now more than 34,000 hospitalists caring for inpatients at medical institutions across the country, performing an array of essential services, including:

- Coordinating medical care
- Serving as attending physicians for inpatients
- Overseeing the transition from inpatient to outpatient
- Co-managing patients with surgeons, internal medicine specialists, and other clinicians

A 2007 study in the New England Journal of Medicine concluded, "The hospitalist model is rapidly altering the landscape for inpatient care in the United States," leading some to ask: What is this new breed of doctors, and how effective are they in improving outcomes for patients?

"Simply put, hospitalists are physicians who have restricted the scope of their practice to the hospital setting. They have a special set of skills,” said Shaun Frost, MD, President of the Society for Hospital Medicine (SHM), in an interview with infocus. "We are . . . [responsible for] making care in the hospital better."
In both their numbers and scope of work, hospitalists are now a mainstay of inpatient care and have helped reframe many of the traditional relationships between patients and the practitioners who oversee them, and responsibilities held within the hospital setting as employed physicians. Hospitalists’ rise to prominence has occasioned some fundamental changes:

- In the past, primary care physicians (PCPs), family doctors, and other medical specialists attended to their hospitalized patients during daily rounds. If a quick decision was needed when doctors were offsite, clinical staff would phone them for directives and guidance. Now, it is hospitalists—not the PCPs—who oversee the care and discharge of hospitalized patients. Residents and nurses, too, have experienced a shift in their roles as hospitalists have increasingly taken over the care of inpatients. It is the hospitalist—not the family doctor or PCP—to whom they look for direction.

- As a unique medical speciality, hospitalists provide a pivotal role inside the health system—including involvement in hospital quality assurance and utilization review activities; teaching of medical students, residents, and fellows; research; and involvement in practice guideline and protocol development.\(^5\)

- From a hospital perspective, use of hospitalists can result in shorter length of stay, lower cost, better quality, and improved patient satisfaction, and can provide a solution for covering unassigned calls. Additionally, the improved availability of hospitalists can result in quicker discharge, more time for consultation, and enhanced communication.\(^4\)

Beyond their central role as clinicians, the hospitalists’ function is consistent with achieving goals for both health care reform and the ACA. “We’re not just super-residents [as we once were regarded],” said Brian Markoff, MD, Associate Professor of Medicine and Hospital Medicine at Mount Sinai Hospital. “We’re highly trained specialists in the care of hospitalized patients and the processes that make hospital care better.”

But how is it that these inpatient doctors have so quickly advanced from being regarded as fill-ins for medical residents to participating as key players in the delivery of care to hospitalized patients?

To grasp the emergence of hospital medicine and its effects on other stakeholders in inpatient care, it is necessary to look at the historical development and expansion of this field. Let us thus consider that history and ask some related questions: Do hospitalists produce better outcomes for inpatients?

What are the altered dynamics of the relationship between hospitalists and other clinicians? How do these changes affect the economics of patient care?

The Evolution of Hospital Medicine

As recently as 15 years ago, hospitalists were often undervalued by other specialists as being no more highly skilled than residents. In the mid-1990s, their numbers were fewer than 1,000 across the United States.\(^3\) But their ranks soon flourished—the growth precipitated by several transformations in health care, including the following:

- Restriction of residents’ duty hours: In 1989, New York became the first state to restrict residents’ duty hours to 80 per week. This move was picked up by individual institutions around the country over time, finally becoming universal to all US hospitals in 2003, when the Accreditation Council for Graduate Medical Education imposed the same 80-hour cap. One immediate result was to diminish a critical source of hospital physician labor—the medical resident—particularly hampering medical coverage at night.\(^6\)

- Rise of health maintenance organizations (HMOs): Another drain on physician staffing of hospitals emerged in the 1990s, when HMOs rose to importance in the medical marketplace. In response, PCPs sought to maximize earnings from their office hours, leaving them fewer hours for rounding. Hospitalists, in turn, filled the gap in inpatient care by substituting as attending physicians.

- Growth of outpatient care: In the mid-1970s, hospital stays averaged 8 to 10 days.\(^8\) As new technologies were introduced, however, an increasing number of procedures that had once required hospitalization were now being performed on an outpatient basis. At the same time, hospital stays were getting more expensive. As
a result, only the most acutely sick patients were hospitalized—typically elderly people with complex and dynamic medical conditions requiring rapid assessment and decision making.9

- **Introduction of diagnosis-related group (DRG) reimbursement:** Medicare adopted a DRG reimbursement program in 1983, changing the terms of payment for hospitalizations from “lengths of stay” to “episodes” of illness. DRGs challenged hospital administrators to streamline care and keep their institutions profitable by shortening average lengths of stay for all patients to balance out shortfalls stemming from patient “episodes” that were not fully reimbursed. A 2002 study by Christopher P. Landrigan, MD, MPH, and others found that hiring hospitalists to attend inpatients effectively reduced lengths of stay and costs of hospitalization.10 It was not long before hospital administrators were viewing hospitalists as mission-critical.

Despite their increasingly central role on the medical/surgical units, inpatient doctors remained unnamed, and their duties undefined, until a seminal article published in a leading medical journal answered the question: Who are these doctors and what do they contribute?

**Defining “Hospital Medicine”**

Robert Wachter, MD, and Lee Goldman, MD, are recognized as the first physicians to examine the phenomenon of inpatient doctors in an academic publication. In 1996, they wrote a *New England Journal of Medicine* article titled “The Emerging Role of ‘Hospitalists’ in the American Health Care System.” “Ideally, the primary care physician would provide all aspects of care, ranging from preventive care to the care of critically ill hospital patients,” wrote Wachter and Goldman. “Unfortunately, this approach collides with the realities of managed care and its emphasis on efficiency. As a result, we anticipate the growth of a new breed of physicians we call hospitalists.”11

In a single stroke, Wachter and Goldman at once named the newcomers and clarified their role.12 The number of hospitalists increased dramatically in the decade following the Wachter-Goldman article. In 2009, an article in a professional journal for hospital administrators gave a historical overview of hospitalists, reporting that “[they] are now a presence in more than half of all US hospitals and their ranks have swelled to more than 23,000 nationwide.” The article continued, “According to recently released survey data from the American Hospital Association (AHA), the number of hospitalists jumped 20%—from 19,000 to 23,000—between 2006 and 2007. The survey was conducted in February 2007 and was sent to about 5,000 community hospitals. Hospitalist programs had been established in 83% of hospitals that had more than 200 beds. In 2007, the average number of physicians in a hospitalist program was 9.4, compared to 8.3 in 2006.”13

With the ascent of hospital medicine (the fastest growing specialty in the history of medical science, according to Dr. Wachter) came the need for a professional organization to provide continuing education and advocacy. Internists John R. Nelson, MD, and Winthrop F. Whitcomb, MD, responded by founding the Society of Hospital Medicine (SHM) in 1997.14 By 2006, the SHM had recorded major strides, including the publication of the society’s first set of core competencies to serve as a framework for the introduction of hospital medicine to medical school curricula and the launching of a peer-reviewed publication, the *Journal of Hospital Medicine*.15 The journal was essential to hospitalists because it gave them a voice, an outlet to publish

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research, a platform for legitimacy in academic medicine, and a forum to demonstrate their value to health care institutions.

Is Hospital Medicine an Efficient Model of Care?
As of 2010, some 59.8 percent of medical centers and community hospitals employed hospitalists to provide inpatient care.16 Even as hospital medicine has gained ground, however, outstanding questions remained about its value to other stakeholders in patient care. Among other issues were the following:

- Hospital administrators needed quantifiable data supporting the position that hospitalists provide an effective and efficient model of care.
- Surgeons wanted to know whether hospitalists would reduce patient risk and mortality.
- Outpatient physicians expressed concerns about being able to provide continuity of care, especially after patients were discharged, because they often had no direct contact with attending hospitalists.
- Nurses and other clinical staff sought to have the role of the hospitalist clarified. If a perioperative patient needed anticoagulant medication, for example, who was going to be the prescriber: the surgeon, the hospitalist, or the outpatient doctor?

All these matters were explored in the context of one larger question: Are hospitalists cost effective as caregivers?

Are Hospitalists Cost Effective?
Hospitalists are viewed by some administrators as increasingly essential to the ability of medical facilities to spend dollars wisely. However, studies about the efficacy of hospitalists and their value to institutions have reached varied conclusions. Some research has supported the notion that hospitalists provide better and less expensive attending care than do PCPs, but other studies have shown otherwise. For instance, a National Health Policy Forum review of literature on this subject concluded that the preponderance of research demonstrates that hospitalists reduce both length of stay and costs—but those savings was being nullified by readmissions of patients. In their article, “Association of Hospitalist Care With Medical Utilization After Discharge: Evidence of Cost Shift From a Cohort Study,” Yong-Fang Kuo, PhD, and James S. Goodwin, MD, looked at 60,000 Medicare fee-for-service patients, measuring lengths of stay, hospital charges, discharge locations, physician visits, emergency department visits, rehospitalizations, and Medicare spending within 30 days after discharge. They found that “patients cared for by hospitalists were less likely to be discharged to home (odds ratio, 0.82 [95% CI, 0.78 to 0.86]) and were more likely to have emergency department visits and readmissions after discharge.” Continuing, the authors said these patients also had fewer visits with their PCPs and more nursing facility visits after discharge. Their findings raised concern because readmissions are now a quality measure. As a result, many hospitals have established readmissions committees to lower that rate and ensure that once patients are discharged, they remain well and do not need to return to the hospital.19

Absent a bright-line resolution to these matters, pressure is ongoing for both medical administrators and hospitalists to demonstrate the fiscal advantages of hospital medicine—particularly in an age of measurable outcomes, when issues of patient safety and profitability are intricately linked. In an interview with infocus (see “The Father of the Hospitalist Movement”), Robert Wachter, the previously cited author who is also chief of medical service at UCSF Medical Center and the current chair of the American Board of Internal Medicine, addressed these concerns. “Hospitalists have to show administrators that having them on the medical units will improve quality and safety; hospitals want that demonstrated,” he said. “There has never been a better time to show we are making a difference as hospital bottom lines get tighter.”

Do Hospitalists Improve Care of Surgical Patients?
Both hospital administrators and surgeons are keenly interested in the proposition that hospitalists can make surgery safer. Increasingly, hospitalists are taking on the responsibility for the medical management of pre- and perioperative patients. This is in contrast to traditional practices in which surgeons oversaw every aspect of care for their patients, including the calibration of medications before and after surgery and the management of complex morbidities, such as diabetes, after surgery. Just as other aspects of hospitalization have changed, however, so has the patient population on surgical floors. Most surgical inpatients today are elderly and ill. In other words, they fall at the high end of risk assessment, with dynamic conditions and complex medical problems—factors that have ushered in an era of surgical patient co-management.20

“‘Hospitalists have to show administrators that having them on the medical units will improve quality and safety; hospitals want that demonstrated. There has never been a better time to show we are making a difference as hospital bottom lines get tighter.’”

—Dr. Robert Wachter
consultant at Overlake Hospital in Bellevue, WA. He recommends the following steps to establish a successful co-management program for perioperative patients, and has implemented them at Overlake Hospital:

- Sit and talk deliberately about who does what. What are the boundaries? How can staff ensure that all tasks are accomplished and nothing is inadvertently missed? Who is accepting responsibility for what?
- Communicate to other hospital staff—particularly nursing staff—about whom to call when there is a surgical patient problem. For example, whose job is it to manage coagulants?
- Establish clearly with all parties that the hospitalist—not the surgeon’s medical assistant—is a full co-manager.

“Often, surgeons may think they have a great partnership because they expect the hospitalist to do all the clerical work and reconciliation. They think, ‘All I have to do is go to the OR, operate for 45 minutes, check the wound for infection [postoperatively], and then bill out.’ That’s not a true co-management relationship,” Dr. Nelson said. “People are trying to sharpen their pencils around these issues and there’s much conversation about how to plug any holes,” he added. (See “FOJP Initiatives: Preoperative Medical Assessment and Co-Management of Surgical Patients” regarding FOJP committee work on establishing guidelines for the co-management of surgical patients.)

The Outpatient Physician and the Hospitalist

Outpatient physicians are increasingly managing their patients with the help of hospitalists, who provide the inpatient care that PCPs and other specialists often cannot deliver anymore because of tight office schedules. Since the hospitalist model was first conceived, outpatient physicians have seen both benefits and detriments flowing from it. The main obstacles to satisfaction have stemmed from issues of communication and continuity of care between inpatient and outpatient physicians.

“Hospitalist care is much more efficient [than rounds],” said Eva Waite, MD, Acting Medical Director of Internal Medicine Associates, one of two primary care practices operated by Mount Sinai Medical Center. However, she added, “The hospital has become a black hole for primary care doctors—even more so if you can’t link to the electronic medical records [EMRs]. Without EMRs, PCPs don’t even know that their patient was admitted, when he/she was discharged, or what happened in between.”

Concerns about discontinuities in care from inpatient to outpatient settings frequently are reflected in academic journal articles, with the points of view of internists and hospitalists laid out in their respective publications.

In a 2012 article in the Journal of General Internal Medicine, Dr. James Goodwin, cited earlier, wrote: “There are advantages and disadvantages to the ‘hospitalist’ model. The potential advantages stem from greater efficiency and expertise from physicians concentrating on just inpatient care. The potential disadvantages derive from discontinuities in care: the unfamiliarity of the hospitalist with the patient, and the communication errors that might occur during transitions from outpatient to inpatient and vice versa, between different physicians.”

The “Father of the Hospitalist Movement”

inFocus spoke with Robert Wachter, MD, Chief of Medical Service at UCSF Medical Center, and the 2012–2013 chair of the American Board of Internal Medicine.

inFocus: As the “father of the hospitalist movement,” you have a historical view of how this specialty has developed. Do you think the role of hospitalists is becoming more important in today’s health care system—especially with the shift to value-based medicine and the emphasis on quality measures and outcomes?

Dr. Wachter: I think that the field is becoming increasingly central to improved health care value. The rubber is meeting the road now. Now, it’s not a question of what we will do, but how we as hospitalists are currently meeting the increasing pressures to demonstrate that we are providing the necessary outcomes. I estimate that in five years, 15 percent of all hospital payments will be hinged to performance.

inFocus: How do you believe hospitalists fit within the current financial model for health care delivery?

Dr. Wachter: There has never been a better time to show that hospitalists are making a difference than now, when hospital bottom lines get tighter. Hospitals need to show that having them there will improve quality and safety—hospitals want them to demonstrate that. When this is true, the value negotiations [over salary] will go well. And if it’s not true, they will be problematic. There are more battles looming about hospitalist pay. If hospitalists depended just on the money that hospitals charge for clinical services, that would not be enough for salary. The reimbursement from Medicare is about 40 percent of payment for hospitalists’ salaries [meaning that hospitals have to make up the rest]. There will be negotiations and, in some cases, battles.

inFocus: How are you addressing these issues at USCF?

Dr. Wachter: We ensure that our trainees understand that part of the job is saving money. What a good doctor looks like today is not only providing high-quality care, but also not wasting money the hospitals don’t have. They must be sure that when they’re ordering a test or treatment it’s not only the best, but also the least expensive.
How Hospitalists Add Value

Hospitalists can provide better care to patients and deliver vital services to hospitals, other physicians, and nurses by filling small, yet important, gaps.

Treating General Medicine and Pediatric Patients
Hospitalists are often called on to treat and admit general medicine and pediatric patients who are not assigned to specific doctors.

Leading Medical Staff
Because hospitalists often see a wide variety of cases, they are well positioned to become leaders in addressing strategic and operational challenges faced by a hospital.

Providing Round-the-Clock Care
Hospitalists who provide onsite coverage at night can improve the quality of care that hospitals offer while increasing patient and nurse satisfaction—and nurse retention.

Improving Patient Flow and Throughput
At every stage of the patient care process—emergency, admission, inpatient unit, surgery, critical care, and discharge—hospitalists can treat more patients and implement other measures to increase throughput and patient flow.

Educating Other Doctors and Nurses
Hospitalists are well equipped to educate physicians and nurses, residents, medical students, administrators, and patients on best practices. They also can serve as informal mentors.

Improving Quality of Care and Patient Safety
Hospitalists contribute to improved quality of care and patient safety—producing better outcomes and more satisfied patients, possibly increasing revenue from pay-for-performance contracts.1


The Expanding Role of Hospital Medicine and the Co-Management of Patients

Responding in general to the issue of discontinuity in care, Dr. Wachter told infocus: “To hospitalists’ credit, this issue [of the handoff from hospitalist to PCP] has been high on their agenda even before [there were] penalties for readmission.” (See “The ‘Father of the Hospitalist Movement.’”)

Dr. Goodwin’s model draws a dichotomy between PCPs and hospitalists, whereas Dr. Wachter describes as many as four variations on hospital care: solo rounding, group practice rounding, shared rounding of inpatients, and hospitalist care. Dr. Wachter acknowledges that inpatient care by hospitalists alone can become disjointed as inpatients transition to outpatients, but again, he credits hospitalists with full awareness of the issue.

Dr. Nelson echoes the concerns of many colleagues in noting that the “handoff”—or transition from inpatient to outpatient—has proven problematic for both hospitalists and primary care doctors. A major choke point has been the flow (or not) of information contained in EMRs. Unless outpatient doctors work for a medical institution, they are denied access to that institution’s EMRs. This means that postoperative treatment protocols are harder to implement, Dr. Nelson said.

According to Dr. Nelson, “No one has the discharging of a patient in these circumstances completely figured out. I’ve been a hospitalist for twenty-five years and the handoff to the outpatient setting is always a concern for me.”

This issue of EMRs falls within the purview of the federal government as it rolls out the ACA. Patrick Conway, MD, chief medical officer at the Centers for Medicare and Medicaid Services (CMS), and director of the Center for Clinical Standards and Quality, told infocus, “We in the federal government are pushing hard to make the electronic health records [EHRs; sometimes referred to as EMRs] as coordinated as possible and are creating new standards and measures so that providers with different EHRs can share information.”

The Future of Hospital Medicine

As the scope of the ACA broadens, so too does the notion of who a hospitalist is and how the priorities and goals of the hospitalist model will evolve. Future trends may include the following:

● The expansion of hospital medicine into specialties. According to data provided by the SHM, 88 percent of hospitalists are trained in internal medicine. However, specialties such as pediatrics, neurology, and even surgery now include doctors who “have restricted the scope of their practice to the hospital setting,” in the words of the SHM president, Dr. Shaun Frost.

● The elevation of patient satisfaction as a chief concern. With patient perception taking on more importance as a quality-of-care measurement, said Dr. Frost, hospitalists will be focusing increasingly on “optimizing the patient and family experience.”

Given the shooting-star quality of its rise to prominence in American health care, some might ask whether hospital medicine is destined to flame out—or is it here to stay? What is the outlook for the discipline at this historic juncture? Time and evolving policies will tell.

In the interim, an encouraging view of the hospitalist model may be found in the Obama administration’s perspective. Jonathan Gruber, MIT economics professor and an architect of the ACA, told infocus, “The
The Expanding Role of Hospital Medicine and the Co-management of Patients

Career Challenges for Hospitalists

Establishing and Re-Establishing Value

A hospital might expect its hospitalists to quickly reduce the length of patient stays. With the passage of time and the fulfillment of expected successes, however, hospitalists must keep proving that the hospital should continue to compensate their practice. Many hospitalists anticipate this challenge by proactively collecting data to demonstrate their continuing worth through length of patient stay, cost per patient, revenue generated, coverage of patients not assigned to other groups, rates of readmission, cost containment, and health outcomes.

Difficulty Quantifying Effectiveness

Other physicians and nurses, as well as patients, often report increased satisfaction when hospitalist programs are in place and functioning effectively. However, patient satisfaction can be difficult for hospital administrators to quantify or value. By presenting positive assessments alongside satisfaction surveys, plus more quantitative data about the effectiveness of care, hospitalists can show how they benefit a hospital beyond pure finances.

Lack of Resources

Hospitalist groups often report not having enough resources on their own. Instead, they depend on other hospital departments to help with administration and the data gathering that would demonstrate their effectiveness.

Building Relationships with Diverse Groups

Hospitalists need to do more than resolve co-management issues with other doctors. They also must work closely with finance, billing, IT departments, hospital administrators, and insurance companies to accomplish all that is expected of them. This requires hospitalists to exercise finesse in dealing with a daunting array of essential business contacts.1

RESOURCES:

5 Society of Hospital Medicine; see note 1.
8 Society of Hospital Medicine; see note 1.
11 Wachter and Goldman; see note 7.
12 Ibid.
14 Ibid.
15 Ibid.
16 “Creating the Hospital of the Future.” American Hospital Association’s Physician Leadership Forum and the Society of Hospital Medicine, 2012.

New York has been a center of innovation in hospital medicine since the field emerged. As the first state to legislate caps on residents’ duty hours at 80 per week, New York has led the way in adapting to changes in the traditional model of inpatient care—that is, rounds by outpatient doctors—and finding new and better ways to care for hospitalized patients. New York-area hospitals face particular difficulties because this region has one of the nation’s highest rates for end-of-life hospitalizations. Therefore, area institutions must be strategic and innovative in optimizing care at their institutions—with a special focus on decreasing readmissions for an elderly and very ill patient population.

Hospitals in New York City have tackled this challenge head on by working cooperatively to develop new safety measures for reducing risks associated with the hospitalist setting. Notable are their new guidelines for the co-management of perioperative patients. Moreover, they are working within their individual facilities to create models of hospital medicine that address inpatient-care concerns that have emerged in an era of value-based medicine and quality measures. These include the following:

- Transitions between inpatient and outpatient settings
- Continuity of care
- Communication among the stakeholders in clinical care: hospitalists, surgeons, outpatient physicians, and nurses
- Patient satisfaction

The influence of New York’s hospital medicine programs reaches far beyond this region because New York is a national—and world—center of medical education. Of the more than 900,000 active physicians in the United States, 17.2 percent received their graduate medical education in New York. Therefore, the models of hospital care in New York’s academic medical centers ripple out nationally, as physicians trained here fan out across the country to practice medicine.

Each FOJP client institution implements its own inpatient care and hospitalist programs individually, but all are dedicated to practicing state-of-the-art medicine aimed at diminishing mortality and readmissions while optimizing patient safety and satisfaction. All FOJP client hospitals take pride in patient-centered hospital medicine departments that set new standards for meeting and surpassing the quality measures and outcomes required by Medicare and the Affordable Care Act (ACA).

Beth Israel Medical Center
Beth Israel Medical Center’s hospital medicine program began in 1999, when the facility hired two physicians to attend to inpatients full time. One of them, Dahlia Rizk, DO, today serves as Chief of the Section of Hospital Medicine at Beth Israel Medical Center and Assistant Professor at Albert Einstein College of Medicine. Her department now consists of 27 hospitalists, a neurohospitalist, and 15 physician’s assistants. Beth Israel instituted its hospital medicine model to attend to patients of the hospital’s primary care teaching practice—Beth Israel General Medical Associates—and to fill in for residents after New York capped residents’ duty hours. Gradually, physicians in the community heard about Beth Israel’s hospitalists and began asking Dr. Rizk about referring their patients to Beth Israel. She responded by expanding the program to accommodate these requests.

“Beth Israel’s operation grew from there,” said Dr. Rizk in an interview with infocus. “New York City sees a lot of hospital closures, and when Cabrini Hospital and St. Vincent’s were shut, we got an influx of patients [and hired more hospitalists],” she explained.

As at all academic medical centers, Beth Israel hospitalists are also the main providers of education for residents. In a 2011 interview, Dr. Rizk explained her philosophy of creating a fully integrated hospital medicine program: “[All] hospitalists . . . are part of one unified program,” she noted, adding that she divides the patient population evenly between the teaching and the nonteaching services. “I am responsible for all the patients who come to us from the entire community referral base,” Dr. Rizk emphasized. “So to me, there should be no difference in the quality or standard of care delivered on any
unit. Eliminating barriers for admitting patients to certain floors is crucial for throughput,” she said.3

Dr. Rizk is currently implementing Beth Israel’s critical illness adult scoring system to help ensure optimum safety for surgical patients—an example of Beth Israel’s teamwork approach to hospital medicine. Once put in place, the surgical scoring system will help guide the co-management of surgical patients at Beth Israel. For surgeons, the system will mean that they can rely on the medical expertise of hospitalists to help guide decisions and monitor the conditions of perioperative patients. Hospital administrators will also benefit. Implementing the system’s pre- and post-surgical guidelines will establish full compliance with tough national standards on continuity of care, readmissions, and best value for the patient—core measures of Medicare and the ACA.

Beth Israel has also instituted a gainsharing program for its referring physicians. Devised by Latha Sivaprasad, MD, Associate Chief Medical Officer at Beth Israel, part of the program provides that physicians with a superior baseline performance receive incentives for inpatient admissions and efficient preoperative and postoperative care.

Montefiore Medical Center
According to the Centers for Medicare and Medicaid Services (CMS), at the top of Medicare’s health care agenda is the reduction in readmissions—the patient, once discharged, stays healthy and at home. Montefiore hospitalists are focused on preventing readmissions with a rigorous program that helps ensure seamless care for patients throughout the discharge process. In addition to minimizing readmissions, patient satisfaction is also a quality measure linked to reimbursement. These scores are now publicly available on the Internet, making it all the more important for hospitals to deliver patient-centered care.

Montefiore’s administration believes that a multi-tiered discharge process is the key to developing methods and standards aligned with Medicare’s health care priorities. The center’s discharge protocols are a prime concern of William Southern, MD, Chief of the Division of Hospital Medicine at Montefiore and Associate Professor at Albert Einstein College of Medicine. “Our group is leading an effort to make transitions from inpatient to outpatient smoother,” Dr. Southern told infocus. He explained that Montefiore has three silos of care post-discharge to ensure that patients receive seamless care:

- Before discharge, all high-risk patients are given an appointment with an outpatient site.
- The nursing service telephones patients within 48 hours after discharge to evaluate the quality of the stay. Dr. Southern describes this as “a courtesy call.”

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Dr. William Southern, Chief of the Division of Hospital Medicine at Montefiore Medical Center and Associate Professor at Albert Einstein College of Medicine.
A contracted management company also calls the patient following discharge and asks about what problems he or she may be having in terms of transition—a hard time getting medications, needing to change an appointment at the outpatient site, or other common issues. If there are problems, the company troubleshoots them with the patient.

Dr. Southern says that he is “trying to coordinate these efforts and make sure that the hospitalists communicate in all three spheres” to provide important information about the patient. The discharge process at Montefiore represents a team effort involving not only hospitalists and outpatient doctors, but also the entire clinical staff, with nursing playing a critical role in patient follow-up. Now counted as a serious quality measure—sometimes called “optimizing the patient experience”—the response of patients to their hospital care has evolved into a priority for medical centers.

Even so, there exists a sort of built-in tension between complete patient satisfaction and a fundamental element of hospital medicine, which is that the patient is attended in the hospital not by his or her familiar primary care physician, but by a stranger—the hospitalist.

Dr. Southern addressed this difficulty, saying, “I get called in at a time of crisis and I don’t know the patient or the family. I take the issue head-on and tell the patient, ‘I’m an unfamiliar face and you are just meeting me. But I am in the hospital all the time, so if you need me, I’ll be there in three minutes.’”

Montefiore Medical Center is well advanced in its use of hospitalist specialists, particularly pediatric hospitalists. At the dawn of hospital medicine in the late 1980s, nearly all hospitalists were internists. Today, 88 percent of hospitalists are trained in internal medicine, with pediatrics being the most popular specialty.

The Pediatric Hospital Medicine Program (PHM) at Children’s Hospital at Montefiore was founded in 2007 by Philip Ozuah, MD, PhD, Executive Vice President and Chief Operating Officer of Montefiore Medical Center. The PHM group has grown rapidly to be the largest in the region, with 17 pediatric hospitalists and 8 physician assistants. A team of 8 FTE academic pediatric hospitalists and 4.5 FTE 24-hour hospitalists provides 24/7 care to about 4,000 pediatric patient admissions per year. It also co-manages all surgical patients under age 13 years of age at the Children’s Hospital. “I truly feel that we are mapping the future of pediatric inpatient care,” Dr. Ozuah said.

Besides providing pediatric education and clinical care, the section plays a vital role within Children’s Hospital. Academic pediatric hospitalists participate in interdisciplinary hospital committees, where they focus on communication, quality improvement, patient safety, patient satisfaction, transitions of care, clinical informatics, and family-centered care.

At Maimonides Medical Center, as at all the medical centers, hospitalists face a common array of similar challenges—
most concerning patient discharge, satisfaction, and medical co-management. It is imperative that these challenges be mastered, as they have a direct bearing on such critical measures as quality, mortality rates, and readmissions.

Ping Zhou, MD, Chief of Hospital Medicine at Maimonides, manages a team of 12 full-time hospitalists and 10 per diem hospitalists. Even though all hospitalists are board certified in internal medicine, “Maimonides hospitalists deal with surgical as well as medical patients. They have a say not only in the care of surgical patients, but also in deciding whether a patient is too high-risk for surgery. Sometimes hospitalists here recommend delaying surgery if it feels unsafe,” she said. “We will advise a surgeon, ‘Hold off. Don’t do the surgery now.’” She added, “Of course, most people are having urgent procedures, and in that case we [the hospitalists] are not giving that type of input.”

One goal of Dr. Zhou’s department is to use the FOJP medical risk assessment tool to optimize care of high-risk surgical patients by making them clinically stable prior to surgery (see “FOJP Initiatives: Preoperative Medical Assessment and Co-Management of Surgical Patients”). “You have to look to the patient’s condition to make the best judgment you can [while taking assessment scores into account],” she said.

Mount Sinai Medical Center

At Mount Sinai, the hospitalist program resides in the division of general internal medicine and has just launched its newest initiative, expanding the program to support vascular surgical patients (see “FOJP Initiatives: Preoperative Medical Assessment and Co-Management of Surgical Patients”).

As in other institutions with solid hospitalist programs supporting medical inpatients, Mount Sinai is tackling the often-cited issue of continuity of care after discharge, along with communication between hospitalists and physicians in private practice. One of the most frequently voiced complaints among primary care physicians nationwide is the gap in patient care caused by the incompatibility of electronic medical record (EMR) software platforms.

Mount Sinai has been taking an active role in exploring improvements for EMR communications. The medical center won an award in December 2012 for implementing a $120 million EMR system that has enhanced quality of care and patient safety in numerous ways. Called the Preventable Admission Care Team (PACT), the program uses EMRs as a tool to reduce 30-day readmission rates for Medicare patients—an important goal of the ACA. (The next edition of infocus will discuss EMRs in greater detail.)

Looking Ahead

The New York area’s leading academic medical centers seldom rest from developing systems and protocols to promote patient safety and quality of care, while minimizing the impact of cost drivers. They carry on adapting to the requirements of value-based care by generating measurable health care outcomes that keep pace with Medicare reform and the ACA.

That is the present. In the longer view, expect evolving legislation and medical practice to place New York’s medical community at the nexus of change—embracing 21st-century health care needs in ways both individual and collaborative.

At least one prominent player finds the outlook exciting. “One of the things that’s thrilling from the seat I’m sitting in is the prospect of following the politics of health care and the Affordable Care Act,” says Montefiore’s Dr. William Southern. “The act’s requirements give us new incentives and new ways of creating innovative programs.”

RESOURCES:


2 Center for Health Workforce Studies, School of Public Health, University at Albany, “The Impact of Graduate Medical Education,” October 2011 Brief.


Primary Care Physicians and Hospitalists

The spectacular growth of hospital medicine over the past 15 years has brought with it significant challenges to private-practice physicians. The hospitalist phenomenon came to public view in 1997, when the “Healthcare Watch” column of Crain’s New York Business reported on a “relatively new medical specialty spreading in the New York area. This specialty consists of physicians who treat patients only in hospitals.” Since then the number of hospitalists in New York and elsewhere has increased steadily, with hospital medicine becoming the country’s fastest growing medical specialty—to the unease of some primary care physicians (PCPs) who have seen inpatient doctors assume the role of principal attendings to patients at most teaching hospitals. Although some PCPs still attend their patients in the hospital, this “rounding” practice is no longer common.

The transformation in inpatient care occurred during an era of tumultuous change in medicine. Medicare became a dominant force in setting the terms of inpatient care. HMOs grew in the medical marketplace and required that doctors see more patients in fewer hours, limiting the time physicians had to be present in the hospital. In addition, hospitalizations became so expensive that only the most ill and elderly patients were admitted, their cases “routinely dealing with life-threatening decompensated organ failures—heart, brain, lung, liver, kidney—as well as gastrointestinal bleeding and septic shock,” wrote a doctor in the journal Physician’s Practice. He concluded, “Their chronic illnesses are either too complicated for outpatient providers to manage, or never get to be managed by outpatient providers because the patients simply bounce in and out of hospitals, nursing homes, assisted living facilities,” and similar places. When hospitalists supplemented physicians on general medicine floors, there was a fundamental shift in the treatment of inpatients that affected the principal patient-care stakeholders: primary care physicians, hospitalists, hospital administrators, and nurses. This constant presence of an expert physician to attend to patients and to consult represented an advantage to all parties. However, there also were perceived downsides that flowed from the intrinsic duality of having separate doctors for outpatient versus inpatient care. These issues included the following:

- Discontinuity of care in the transition from outpatient to inpatient settings
- Change in the relationship between private-practice doctors and their patients, with patients feeling disconnected from the hospitalists attending them, and physicians feeling disconnected from the hospitalization process
- Poor communication because of the lack of access that many PCPs have to their patients’ hospital medical records
- Loss of income to doctors in private practice

The 1997 Crain’s article raised issues about the hospital medicine model that are as relevant today as they were when the piece was published: Do hospitalists offer better care to patients, while at the same time saving time for PCPs who don’t make rounds? Is care by hospitalists best, both from a medical perspective and in terms of the patients’ overall comfort and well-being?

Continuity Conundrum

The care of inpatients by hospitalists may be regarded as more efficient, but at times the model of having both an inpatient and an outpatient physician for the same person may create an information breakdown. A primary care doctor wrote in an “Ethics Forum” in American Medical News, “Hospitalists, seeing a very sick patient for a short period of time, never have the chance to develop an understanding of that person’s history, behavior and preferences, or of the resources available to him or her upon discharge.”

Moments of transition are pivotal to both PCPs and their patients. Many PCPs feel frustrated that their knowledge of a patient—from emotional issues to medical history—cannot be accessed by the hospitalist. It also irritates many PCPs that, on the back end of a hospitalization, they get what they consider incomplete information from the hospitalist about the inpatient care. This is especially a problem if the PCP has no affiliation with the hospital of record, and cannot access the electronic medical records (EMRs) from the patient’s stay.

Discontinuity of care is also a problem for hospital administrators. In an era when hospital readmissions are a quality measure—affecting reimbursement from Medicare—it is critical to have information flowing between hospitalists and primary care doctors during the phases of admission and discharge, to ensure that patients receive seamless care. If either PCPs or hospitalists lack sufficient information on a patient’s condition before, during, or after hospitalization, there is a greater chance for medical errors and adverse events. A study
of 400 patients published in the *Annals of Internal Medicine* in 2003 reported that 19 percent of discharged patients experienced adverse events soon after hospitalization and that at least half these events could have been avoided or mitigated with better communication between outpatient and inpatient doctors.7

A study focusing on chronically ill patients, published in the *American Journal of Managed Care* in 2011, concluded, “Better continuity of care was associated with less health care utilization and lower health care expenses.”8

Therefore, PCPs and hospital administrators—as well as other stakeholders in a patient’s care—have a shared interest in developing methods and standards that smooth the transition of care while aligning with Medicare health care priorities, such as reduced readmissions. An editorial in the *Journal of General Internal Medicine* asserted that “the hospitalist movement has arrived and . . . efforts should be targeted to improving the coordination of care between primary care and hospitalist physicians.”9

**Improving Handoffs**

The transition from inpatient to outpatient has been studied closely by John Nelson, MD, a co-founder of the Society for Hospital Medicine (SHM), and a hospitalist consultant at Overlake Hospital in Bellevue, WA. Examining the issue from the perspective of the PCPs with whom he coordinates patient care, Dr. Nelson told *infocus*, “I advise that every patient be handed a typed copy of the discharge summary,” he said. “In every report a hospitalist dictates, he should cc the other stakeholders and say who was copied on the report. Then, get it to the primary care doctor by the close of business that day.” However, because PCPs are not always informed of a patient’s discharge, Dr. Nelson also advised that outpatient doctors need to monitor their fax machines and electronic communications to look for patient discharge information.

In 2004, the Society of Hospital Medicine and the Society of General Internal Medicine formed a task force to address issues in handoffs between PCPs and hospitalists. Led by Mary Jo Gorman, MD, MBA, and Sunil Kripalani, MD, the task force “examined what can and does go wrong in the all-important handoff period.” It concluded that:

- Discharge summaries don’t reach the primary care physician up to 25 percent of the time.
- Half or more of discharged patients contacted their PCP before the physician received any discharge information, including notification that the patient had been hospitalized. Only 17 percent of PCPs reported receiving notification from hospitalists before their patients were discharged.
- The lack of information or delay in its arrival prevented optimal outpatient management in an estimated 10 to 15 percent of cases.
- Missing information in discharge summaries is a serious issue. Summaries sometimes lacked the patient’s full name, discharge date, diagnoses, lab results, names of the inpatient and outpatient physicians, tests pending at discharge, and discharge medications.10

**Advice for Primary Care Physicians on Communicating with Hospitalists**

The following tips are presented to assist primary care physicians’ communication with hospitalists about the PCPs’ patients who have been admitted as inpatients:

- **Provide verbal reports when necessary.** If there is a social issue or piece of the patient’s medical history that will assist the hospitalist, a simple phone call to alert the hospitalist may reduce the length of the patient’s hospital stay. Remember, you know your patient better than the hospital staff does.
- **Perform outpatient workups after the patient is discharged.** Your hospitalist may agree to run tests you request while the patient is hospitalized, but insurers are unlikely to reimburse unless the tests are directly related to the admitting diagnosis, financially burdening the hospital. In addition, unnecessary tests may add days to the hospital stay. If the test or evaluation can be done when the patient is an outpatient and has nothing to contribute to the current treatment, plan to do it after discharge.
- **Do not do an “end run” around the hospitalist.** Even if you defer most of the care to the hospitalist, if you have hospital privileges you may be tempted to try to control your patient’s pain or other symptoms yourself while the patient is in the hospital, for instance. This will only fragment the patient’s care and confuse the nursing staff. Instead, call the hospitalist and offer your suggestions.
- **Expect a timely discharge summary.** When the patient returns to your care a few days after discharge, you need to know the patient’s new medications, test results, and plans for further workup. If your hospitalist has not dictated the report, you should call him or her and ask for a verbal summary.
- **Provide feedback.** If many of your patients comment that a hospitalist was rude or inattentive, you may wish to discuss it directly with the hospitalist or with his or her supervisor. Conversely, if your patients rave about a specific physician, share that, too.

The relationship between the PCP and the hospitalist need not be adversarial. After all, both providers want to achieve the same results: a short hospital stay, effective communication, a safe discharge plan, and a good outcome for the patient.1

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Primary Care Physicians and Hospitalists

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Based on the findings of the joint task force, the hospitalists and internists also produced the following recommendations to increase the quality and efficiency of patient care:

- Ensure confirmation, on patient admission, of the primary care physician’s name, address, phone and fax numbers, and e-mail address. The outpatient physician’s preferred method of receiving discharge communications should also be identified.

- The inpatient record should be read, initialed, and filed by the outpatient doctor.

- Ensure that, at the very least, a brief, structured discharge document—a letter or note to precede the full summary—is prepared and delivered on the day of discharge.

- Train new physicians to avoid writing overly long documents, which likely go unread, keeping the length of the comments to a one- to one-and-a-half-page document that the outpatient physician can look at briefly.

- Ensure that the medical content of discharge summaries covers the basics: discharge medications (and reasons for changes); discharge diagnoses; results of procedures or abnormal labs; needed appointments or other follow-up; pending tests; and specialist consults and conclusions. The patient’s functional status at discharge should also be included, along with related instructions.

- Arrange for delivery of detailed discharge summaries to the outpatient physician within seven days. Some studies have found a lag of up to three weeks, Dr. Kripalani said.11

Additional Challenges

The lack of compatibility among EHRs contributes to discontinuity in health care. Unless a physician has access to a hospital’s EHRs—for example, by working in a hospital-owned practice or being on staff—there may be a communication gap between the EHRs of the hospital and those of the physician because their programs do not necessarily “speak” to each other. This is a problem so widely acknowledged that the Obama administration is investing more than $27 billion in incentives over 10 years for a national system of EHRs that will be available to all health care providers—so the information “follows” patients to different health care delivery sites, from physicians’ offices to hospitals to outpatient surgery centers.12

Another possible solution to discontinuity may lie in required performance reporting by hospitals. With today’s “report cards” on health care institutions posted on the government’s “hospital compare” website, PCPs can research local medical centers and direct their patients to the institutions with the best outcomes—thus, PCPs’ economic clout could give them a greater say in hospital care. Writing in The Hospitalist, Larry Wellikson, MD, FHM, declared: “The expanding role of the PCP as the informed guide for their patients . . . will drive hospitals and all physicians who rely on referrals to improve their feedback and communication with PCPs.”13

Since the advent of hospital medicine, studies examining outcomes of care by PCPs versus those of hospitalists have been numerous and inconclusive. The research has provided data both supporting and questioning the notion that hospitalist care is more cost effective. For example, as stated previously, a National Health Policy Forum review of literature about hospitalist care concluded that most research demonstrates that hospitalists both reduce length of stay and lower costs.14 Furthermore, a 2009 study found a positive correlation between hospitalist care and better health outcomes.15 However, a 2011 study in Annals of Internal Medicine reported otherwise: Hospitalists were successful in cutting lengths of stay and costs—but the savings was being nullified by readmissions of patients.16

Patient Satisfaction and PCPs

In the 21st century, patient satisfaction is more than an important variable in care—it is a quality measure. Because patient-centered care drives the Affordable Care Act, reimbursements are determined by patients’ perceptions of their hospital experiences—and those perceptions may well depend on their expectations about what their hospitalization will entail. This, in turn, hinges on their relationships with their primary care doctors, who manage patient expectations for hospitalization. This, then, affects patient satisfaction scores—a great source of concern to hospital employees and administrators. “There still is a lack of understanding on the part of the public that the PCP may not be the one providing the care when in the hospital,” said Shaun Frost, MD, President of the Society for Hospital Medicine in an interview with infocus.

Should continuity of care play a part in patients’ expectations as they transition from outpatient to inpatient settings? “It makes a much smoother transition to an inpatient setting if their primary care doctors—with whom patients have a longitudinal relationship—prepare them emotionally for the hospital stay, and do this in a time of calm,” said Dr. Frost. To help patients transition to a hospital unit, he suggested that primary care doctors may want to do the following:

- Clarify each patient’s expectations for the hospital experience.

- Communicate to the hospitalist what these expectations are.

- Document the patient’s expectations as part of a medical record.

- Have this conversation with the patient while he or she is still well—before crisis hits.

- Explain to the patient at which hospitals the PCP does rounds, if that is the case, so the patient has this information beforehand.

The importance of the relationship between the primary care physician and the patient was the subject of a study conducted at the New England Medical Center. The researchers examined three key aspects of patient
care: adherence to physicians’ advice, patient satisfaction, and improved health status. The study concluded that patients’ trust in their physician and physicians’ knowledge of patients are leading correlates of self-reported health improvements, including integration of care, communication, comprehensive knowledge of patients, trust, and thoroughness of physical examinations. The results are noteworthy in the context of pervasive changes in the US health care system that are widely viewed as threatening to the quality of physician-patient relationships.15

Financial Considerations

When primary care physicians cut back on their rounds, or ceased doing them completely, they lost a source of revenue because they could no longer bill for hospital visits. As a result, there was a widespread perception among PCPs of significant pressure on them financially, and a feeling that this was an issue hospital administrators should try to address.16

One answer from hospitals has been gainsharing—an incentive system designed to involve PCPs in working efficiently and in driving institutional growth. One example of gainsharing is a program at Beth Israel Hospital devised by Latha Sivaprasad, MD, Associate Chief Medical Officer and Chief Patient Experience Officer, and colleagues. In the Beth Israel program, physicians with a superior baseline performance receive incentives for inpatient admissions and “efficient preoperative and postoperative care.” A study of this program, “Quality and Financial Outcomes from Gainsharing for Inpatient Admissions: A Three-Year Experience,” reported positive outcomes resulting from the following:

- Physician participation that was voluntary
- Payments made to physicians without risk or penalties from participation
- Incentives based on individual performance
- Nonsurgical admission incentives that were intended to offset loss of physician income related to more efficient medical management and reduced hospital lengths of stay

Even with gainsharing programs, though, a perception persists among PCPs that private practice as a model is less financially viable than it once was. This notion is seen to be driving more young doctors to choose careers in which they are salaried employees of hospitals rather than independent practitioners. To illustrate: A decade ago, two-thirds of medical practices in the United States were owned by physicians, but by 2008, less than half of doctors nationally were hanging out a shingle.19

Bridging the Great Divide

“The evolution of the private practice clinician has been dramatic in recent decades, with most now relying on hospitalists to manage inpatient care. The benefit of this is the 24/7 presence of a physician to monitor the acutely ill and elderly patients who now populate medical/surgical floors. As the infrastructure of US health care changes, the relationship between outpatient and inpatient doctors can be expected to shift accordingly, casting them as key players on a team that includes hospital and office nurses, consulting specialists, social workers, and others.

Despite their differences, both sides of this debate acknowledge that it is of utmost importance to patients that hospitalists and PCPs have constructive working partnerships. These partnerships should bridge the gap in care between the hospital and the doctor’s office, working cooperatively to deliver patient-centered care with best outcomes. One physician summed up his view of an optimal relationship this way: “In an ideal world, the hospitalist and primary care physician negotiate a robust form of professional courtesy that reflects a mutually accepted partnership, characterized by frequent, timely and accurate communication that ensures good coordination of care.”20

RESOURCES:

11. Ibid.
18. Leykum and Mortensen; see note 9.
20. Smith; see note 5.
FOJP Initiatives: Preoperative Medical Assessment and Co-Management of Surgical Patients

Health care reform is based on enhancing the effectiveness of care while improving quality and outcomes, minimizing risk and errors, reducing readmissions, and improving patient satisfaction. Reshaped health care will be centered on the patient and delivered by teams of health professionals. How can we advance and support the creation of this type of environment?

Throughout health care there has been an increasing call for performance standards and quality improvement—all in the context of using resources more efficiently. How will our health systems enhance coordination of care with physicians, surgeons, nurses, and other health professionals; improve teamwork; and promote more efficient management of resources? FOJP’s SWAT Team (see sidebar, next page) was formed specifically to answer these questions and others geared toward building best practice guidelines, processes, and procedures, along with appropriate metrics to be shared among all client institutions and compared with national databases.

One SWAT Team project, the development of a standardized preoperative medical assessment tool, arose from the need to improve communication between medical and surgical teams when admitting a patient. Another goal of this project was to avoid expenses associated with canceled procedures due to inadequate preoperative patient assessments.

Coordination of care across all providers should improve patient safety and outcomes. Another SWAT Team project is focusing on the expanded role of the hospitalists, the on-site health professionals who are committed to changes in quality, systems improvement, patient safety, and efficiency, to support the co-management of the perioperative patient.

SWAT Team Project for Preoperative Patients

To date, the SWAT Team and the preop evaluation workgroup have completed recommended guidelines for the optimal care of high-risk patients being admitted for surgery. The preoperative medical assessment has recently been implemented as part of the EHR in each of the FOJP client hospitals. This assessment covers a broad area of evaluation, including categories such as anticoagulation and anti-platelet agents, cardiac risk, diabetes, and medication management, each of which is subdivided to create a comprehensive score of a patient’s surgical risk. “The SWAT Team itself, as well as its associated committees and workgroups, is a rich and useful collaboration of intelligent and passionate colleagues committed to streamlining processes for safety, quality, and improved outcomes. As results are seen and being documented at each of the hospital sites, it inspires and encourages everyone to achieve similar goals,” said Latha Sivaprasad, MD, Associate CMO and Chief Patient Experience Officer at Beth Israel Medical Center. Dr. Sivaprasad was the SWAT Team leader responsible for the development of the preoperative medical assessment template.

Although the assessment is subject to the judgment of each of the medical providers, it is based on the considerable knowledge and experience of the SWAT Team, the preop evaluation workgroup, and an exhaustive review of the professional literature. “When we first started our work with the preoperative assessment tool, we were able to establish a set standard of care,” said Dahlia Rizk, DO, Chief of the Section of Hospital Medicine at Beth Israel Medical Center, project director for that site, and member of the workgroup. “These guidelines will have a positive impact on mortality because they will enhance safety and improve patient outcomes.” Dr. Sivaprasad added, “The assessment tool really helped to promote critical and timely conversation between anesthesia, medicine, and surgery in an effort to integrate past medical history, clinical rationale and risk into the discussions and decisions before surgery.”

Next: Surgical Co-Management for the Perioperative Patient

Evidence is building that hospitalists in medicine have the ability to better manage hospital resources and, in the process, lower average lengths of stay and reduce health care expenditures for hospitalized patients. Furthermore, hospitalists have unique insights into how best to deploy and improve best practices and standards of care, along with health information systems, because they are intimately involved in systemic quality and efficiency improvement efforts inside the hospital system.

“Co-management is a means to improve the quality, speed and delivery of care, as well as to reduce the cost of care,” said Ronald Kaleya, MD, Chief of Surgical Oncology at Maimonides Medical Center and the FOJP SWAT Team member leading the project to develop best practices for perioperative patient care. “The data today show that the application of co-management models in orthopedics can yield significant results in quality and patient satisfaction,” he said. “We need to move beyond that specialty and prove that hospitalists providing inpatient medical care for patients in neurosurgery, vascular surgery, and other specialties can drive similar reductions of cost and risk, while improving quality and outcomes.”

Co-management requires clearly defined roles, collaborative professional relationships and documented agreements, and some sense of equal standing with the surgeons or other specialists who call on hospitalists to care for their hospitalized patients’ medical needs. Quality metrics for co-management—which are being gathered from the outset to provide a baseline—may include in-hospital morbidity and mortality rates, 30-day mortality, hospital readmissions, length of hospital stay, costs of care, and overall return on investment for the hospital, as well as improved patient and professional satisfaction. “Our co-management surgery committee is now creating the key data points for FOJP to monitor as each institution identifies the hospitalist-specialty project that will be part of the trials monitored in order to establish best practice guidelines for all,” said Dr. Kaleya.

Mount Sinai Medical Center Pilot Project Launched

Mount Sinai Medical Center’s pilot project for co-management between
vascular surgeons and hospitalists was launched in January. This pilot project is the first one to start advancing the concept of co-management within the FOJP group of institutions beyond orthopedics. The service agreement between these cohorts involves a statement of background and purpose, as well as guidelines for handling logistical and clinical issues, the discharge of patients, and even conflicts or disagreements within the team. The agreement ensures that the team is truly collaborative and that both surgeons and hospitalists on the team will actively participate in medical decision making.

The Mount Sinai co-management team worked hard to iron out important details, such as the following:

- Who will communicate with house staff and other surgery providers about recommendations for plan of action and treatment of the patient? [Hospitalists]
- Who will communicate with the patients and their families regarding the medical plan of care, goals, treatments, and options? [Hospitalists]
- Who will answer calls from the nursing staff when problems arise? [Surgeons]
- Who will be responsible for admission and discharge medicine reconciliation? [Surgeons]
- Who will decide on pain management issues? [Surgeons]
- Who will call in subspecialist consultations? [Hospitalists and surgeons in collaboration]

In addition, all program participants are expected to communicate directly for the day-to-day care of the patients and to resolve conflicts quickly and with each other in “a courteous, fair and professional manner,” as stated in the agreement.

The program’s hospitalist champion is Alan Briones, MD, Assistant Professor of Medicine in the Division of Hospital Medicine at Mount Sinai, and an active member of the FOJP co-management surgery committee. The surgical champion is Rajesh Malik, MD, Assistant Professor of Surgery and Assistant Professor of Radiology at Mount Sinai, specializing in vascular surgery, also an FOJP committee member. Both are optimistic about the program.

“This program is designed to ensure better continuity of care and a good handoff to the primary care physicians,” said Dr. Malik. He was particularly gratified that “the junior residents, who will have to tackle many of these problems in their career, are seeing a good example of teamwork and quality patient care. Now, they have someone to ask about medical issues such as 'How do you manage multiple medications in patients?' This will help reduce errors in medication and other risk areas. The residents are excited to have someone to check in with 24/7,” he said.

In particular, Dr. Malik appreciates the program’s enabling him to have a single point of contact for medical decisions: Dr. Briones. “I used to have to deal with seven or eight consulting doctors,” Dr. Malik said. “Now we have one point person.” Evaluating the pilot program in the context of national health initiatives, Dr. Malik added, “The Affordable Care Act is demanding reduced readmissions and complications—and this is exactly what the pilot is designed to accomplish.”

When assessing the co-management pilot, Dr. Briones said that the easiest aspects of shared decision making were the more logistical questions, such as when to start rounds for new patients. The hardest, he explained, “were the clinical issues, with the most difficult of those being when to call in consultations for subspecialists. We had to agree on who makes that [judgment] call. For example, a surgeon may feel we need an infectious disease consult and I think it may not be necessary.”

The Future of Co-Management

Beth Israel Medical Center, which will be launching its pilot co-management project this spring, is currently writing service agreements between general and vascular surgeons and hospitalists. Maimonides Medical Center is setting the stage for a co-management project focused on general surgery that will launch later in the year. Montefiore Medical Center plans to establish guidelines for a relationship between colorectal surgeons and hospitalists.

Co-management clearly has the benefits of promoting a sense of cooperation and familiarity among colleagues, and allows for true professional relationships to develop between surgeons and hospitalists. Putting FOJP’s surgical safety initiatives into a broader context, Dr. Kaleya said, “The thing that differentiates a great hospital from a great hospital is the successful minimization of the risk of failure—and these new best practices that we are gleaning from these pilot initiatives by capturing real data will enable some of the country’s finest medical centers to become that much greater.”

What Is the FOJP SWAT Team?

Physician leaders and innovators selected by FOJP hospital CEOs serve on a committee known as the SWAT Team.

This highly motivated group of physicians identifies best practices, coordinates implementation strategies across their hospitals, and measures results of cutting-edge initiatives for increasing patient safety and improving health care quality at FOJP hospitals.

SWAT Team members include:

- Michael Brodman, MD, Professor and Chair, Obstetrics, Gynecology and Reproductive Science at Mount Sinai Hospital
- Ronald Kaleya, MD, Chief of Surgical Oncology at Maimonides Medical Center
- Peter Shamamian, MD, Chief of General Surgery and Chief Quality Officer at Montefiore Medical Center
- Latha Sivaprasad, MD, Associate CMO and Chief Patient Experience Officer at Beth Israel Medical Center
From the Chief Nursing Officer

The Nurse’s Role in Hospital Medicine

Nurses are accountable for the coordination of patient care. Nursing practice is evidence-based and blends research, knowledge, and technology with individualized, compassionate approaches to care. These highly trained and skilled individuals are responsible for:

- Monitoring patients’ progress and identifying changes in their health
- Acting on any changes to ensure the patients’ comfort and safety
- Administering prescribed medication and treatments
- Recording patients’ medical histories and assessments
- Providing information and advice on medical conditions to patients and their families
- Delivering health management training to patients and their families
- Educating patients and family members for discharge, which can reduce the risk of post-hospital complications and readmission

Few would argue that the role of the nurse is not essential to the care of the patient.

What Has Changed under the Hospital Medicine Model of Care?

First, hospital medicine has accelerated the changing dynamics of the inpatient team by chipping away at the hierarchies that existed between nurses and physicians. Physicians have historically been perceived as the dominant authority in patient care, whereas the main function of nurses was carrying out orders.

Second, more than ever—and consistent with process-improvement research that identifies the active involvement of front-line staff as a critical factor in making and sustaining change—processes for engaging nurses and other front-line staff have expanded. Patients and their families understand that nurses’ work is physically and emotionally demanding but are also beginning to recognize the substantial intellectual and organizational competence that nurses provide. Among the critical tasks carried out by nurses are (1) ongoing monitoring and assessment of their patients and, as necessary, initiating interventions to address complications or reduce risk; (2) coordinating care delivered by other providers; and (3) educating patients and family members for discharge, which can reduce the risk of post-hospital complications and readmission.

Finally, a third benefit of the relationship between the nurse and hospitalist is the ability to deal immediately with emergent issues for the patient. Evidence shows that involving patients and families in care promotes safety, helps avoid errors, saves time, and builds relationships. The data collected to date indicate that because of this better collaboration among services, staff communication improves, length of patient stays is reduced, and patient satisfaction rises.

Influence and Status

Concern still exists for potential areas of overlap and responsibility when defining the roles of hospitalists and nurses, so the need to clarify expectations is critical. Although there are no hard and fast rules about solving potential conflicts, some common-sense procedures can help define the relationship:

- Create opportunities for collaboration and communication.
- Seek training and educational programs for nurses and physicians that focus on improving teamwork and building relationships (e.g., conflict management, collaboration skills, TeamSTEPPS™).
- Establish mutually shared goals and expectations emphasizing the need for patient safety, quality of care, and satisfaction.
- Share responsibilities for all handoffs of the patient—between shifts, at night, on weekends, and on discharge. So much depends on handoffs in terms of patient continuity, safety, and avoiding readmissions. Establish a process that is efficient for both physicians and nurses. Do not underestimate how challenging communication can be, so take the time to complete all paperwork—including summaries, patient and family conversations, medication reconciliation, and all other patient and patient-family interactions.

Outlook for the Future

The nursing role is evolving rapidly as nurses are tasked with an even wider range of health care responsibilities. With the expansion of hospital medicine, nurses, working side by side with hospitalists, will assist patients and their families with the multifaceted demands of hospitalization, discharge, and their reentry into the outpatient community or other care facilities. The nursing profession is becoming more than just performing tasks and procedures; it is now about being a more effective member of a health care team while navigating new clinical and informational systems. Emerging technology is at the forefront of more cost-efficient care delivery; nurses who can adapt and implement these changes will become sought-after leaders, both inside and outside the hospital setting.

Although the job of the nurse will remain as caregiver and advocate for the most sick and vulnerable within our communities, nursing leaders must also focus on quality measures and the role nursing will play in meeting national standards. Ultimately, to reach the goal of a safer and higher-quality health care system at an affordable price, nurses should continue the path of redefining and expanding their roles, championing quality-of-care improvements, spearheading research innovation, demonstrating the use of evidence-based practices, advocating for patient rights, and challenging the status quo.

With so much focus in health care delivery on quality and safety, the rapid growth of hospital medicine and hospitalists as part of the clinical staff comes as no surprise. Literature indicates that the hospitalist movement should impart value to the health system and patient care, inpatient safety and quality, economic efficiency, access and availability, satisfaction, and leadership and education. Today, data show improvements in patient length of stay; however, the tools to measure hospitalists’ role in patient satisfaction are far less than adequate. It is necessary to continue to drive hospitalist initiatives, including increased need for patient co-management, to reduce patient readmissions, eliminate medication errors, lower cost of care, and improve financial reimbursement in the pay-for-performance model.

Consider the trends: Neurohospitalists are becoming popular in hospitals seeking to become “stroke centers” because of the ability to have a hospital-based neurologist on hand for complex brain cases. Obstetric hospitalists, or laborists, are a growing trend in the hospitalist movement, in part because of the increased patient safety and lower malpractice risk they provide to patients.1

A perioperative hospitalist also represents a special kind of hospitalist physician with expertise in caring for postoperative patients, specifically focusing on their co-morbidities. Recent studies examining outcomes of patients undergoing elective and urgent orthopedic surgery with surgeon-hospitalist joint care have shown that patients co-managed by hospitalists had faster time to surgery, fewer postoperative complications, fewer transfers to intensive care units, and shorter length of stay compared with patients being cared for by primary care physicians.2,3 Why not advance co-management to other specialties?

As you read in this edition of infocus, this is what is happening at FOJP hospitals. The surgical co-management committee at FOJP is establishing standard metrics that will be tracked by each institution’s co-management programs. Once the data are collected and analyzed, they will be used to set best-practice standards for the co-management of all surgical patients and create benchmarks for comparison—among FOJP client hospitals and nationally—all leading to demonstrate quality of care improvements, closing gaps in communications between hospitalists and outpatient physicians, and identifying innovative system solutions from hospitalists regarding documentation and handoffs.

Looking Forward

Documentation best practices and challenges in the written and digital age will be the subject of our next edition of infocus. Clinical care is judged on documentation—either in support or failure to support the competency of care. We will thus discuss the “rights and wrongs” of documentation and the impact from a risk, quality, and safety perspective. We will also review the current status of the electronic health record (EHR) and implementation strategies in the hospitals and individual practice settings in light of the 2014 ACA meaningful-use requirements. Topics discussed will include benefits of the EHR, the impact on efficiency and coordination of care, and challenges due to lack of functionality, costs, and standards for health care reporting. The EHR solves many of the problems inherent in paper documentation but unfortunately creates new problems unique to electronic documentation. We will review these as well.

This next edition will engage the chief medical information officers from FOJP client hospitals who will provide information on the adoption of electronic applications by clinicians, along with using the EHR to optimize quality, safety, and efficiency in their workflows, while balancing compliance, security, ease of use, and the automation of manual processes.


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In the Next Edition...

Electronic Health Records: A Status Report for Hospitals and Office Practices