REIMAGINING INPATIENT CARE

THE NEXT GENERATION OF HOSPITAL MEDICINE

SCP HEALTH

TOGETHER, WE HEAL

Rachel M. George, MD, MBA
Executive Vice President and
Chief Medical Officer
SCP Health

FOREWORD

It's hard to believe that just a few short months ago, my colleague Lisa Fry, SCP Health's Chief Growth Officer, and I hosted a webinar discussing the future of hospital medicine. At that time, COVID-19 was just coming into focus for us as a nation. The first cases had already been identified in the US, but no one expected that we would be mourning over 100,000 deaths due to the novel coronavirus. Since then, we've pivoted and transformed to adapt to the challenges and opportunities COVID-19 has revealed. What we now understand, more than ever, is the imperative need for sustainable hospital medicine programs across the country.

Despite the virus outbreak, the information and tools imparted here are every bit as important – if not more – than when we originally shared this content via webinar in Feb. 2020. Take a moment to refresh your perspective, reevaluate your HM program's success, and prepare a strategy for whatever may come next in healthcare.

SCP HEALTH
TOGETHER, WE HEAL

INTRODUCTION

It was just over twenty years ago when the Hospital Medicine specialty began to emerge. Since 2003, the number of hospitalists has grown by more than five times. Though its growth has been enormous and its practitioners are highly respected, Hospital Medicine (HM) is a very young specialty and most programs have significant opportunities to further evolve. This reality was made clear with the COVID-19 pandemic, as many healthcare organizations rushed to set up a structure that could handle such a large-scale global crisis. Though we can never fully prepare for something of this magnitude, there are several steps hospital leaders can take to build a well-equipped program ready to navigate these types of unforeseen challenges. The first is to develop a tailored strategy to capitalize on the potential of Hospital Medicine and expand its impact.

In this white paper, readers will gain a deeper understanding of:

- the beginnings of HM and how that colors the way the specialty is practiced today,
- our tiered model of HM program development—and how to evaluate where a program lands,
- how other hospitals are approaching HM advancement, and
- what is needed to navigate the future of inpatient care.

Ultimately, this white paper provides an opportunity to gain a better grasp on the evolution of HM, what success looks like in the current landscape, and how HM programs and hospitalists can prepare for the next generation of the specialty.

THE EVOLUTION OF HOSPITAL MEDICINE

The HM specialty grew out of a few simultaneous points of origin.

1. **Community-based physicians needed to maximize office time**
As primary care physicians felt financial pressure to increase productivity and expand their reach into the patient population, they had dwindling time available to round on their hospitalized patients.

2. **"Closed-panel" HMOs were employing their own physicians to round on inpatients**
Also feeling the need to improve efficiency and effectiveness, companies like Kaiser Permanente, Humana, and others worked to reduce length of stay and improve outcomes by hiring dedicated physicians to monitor hospital patients.

3. **Health crises augmented the need for a care "quarterback"**
In the late 1990s, the AIDS epidemic severely burdened inpatient wards.[1] Regularity and consistency in rounding, treatment, and education was highly necessary—but practically nonexistent. In the midst of that crisis, the idea of a centralized, informed physician to run point on a person's inpatient stay started to take real shape.

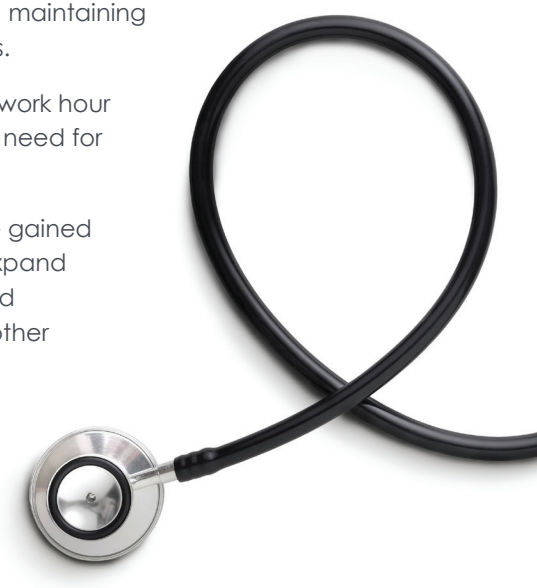
In August of 1996, Dr. Robert Watcher and Dr. Lee Goldman published "The Emerging Role of 'Hospitalists' in the American Health Care System" in the New England Journal of Medicine—presenting what they thought was a better way of handling inpatient care. As stated earlier, the hospitalist model was already being experimented with in community settings, but Dr. Watcher and Dr. Goldman launched it into the academic world and gave it a name.[1]

Hospitals found that adopting an HM program and staffing hospitalists was beneficial to not just patient satisfaction—but provider satisfaction. Recruiting and retaining specialists was easier when the hospitals could promise a more balanced lifestyle with less call rotation for unassigned patients.

Once smaller and more rural hospitals started catching on to the trend, they began offering the "seven on, seven off" schedule to attract physicians to work for them without having to relocate. This allowed physicians to fill open roles by concentrating their on-shift time at these out-of-town hospitals while still maintaining their home life during their off weeks.

In the academic sphere, residency work hour restrictions resulted in the increased need for HM programs as well.

As both the concept and the name gained recognition, hospitalists began to expand their scope well beyond "unassigned patients" and began working with other specialties in "co-management."



THE CURRENT STATE OF HOSPITAL MEDICINE

If its impact wasn't significant, HM wouldn't have grown as rapidly as it has. Recent studies and surveys have found that there are around 50,000 hospitalists in the United States[2], hospitalists work in over 80% of hospitals with 200+ beds[3], and 80% of hospitalists would choose the HM specialty over again[4].

Why has it become so prevalent? What are the benefits? How does HM fit into the healthcare landscape? The answers are found within three perspectives: provider, hospital, and patient.

BENEFITS OF A DEDICATED HOSPITAL MEDICINE PROGRAM

PROVIDER PERSPECTIVE

For community private practice clinicians, the benefits still reflect what we saw in the origin story: efficiency for their practice time and more attentive hospital care for their patients.

For dedicated HM providers, there is protected time off (work-life balance) and patient volumes are driven by the hospital. Additionally, they don't need to build their own private practice and can specialize in inpatient internal medicine. The experience of caring for a high-acuity patient over a short period of time and being able to safely send them home is deeply gratifying.

around
50,000 hospitalists
in the United States[2]

hospitalists work in over
80% of hospitals
with 200+ beds[3]

80% of hospitalists
would choose the
HM specialty over again[4]

HOSPITAL PERSPECTIVE

For systems and facilities, the benefits of a well-run HM program span three categories: growth and reputation, quality and clinical outcomes, and financial performance.

- ***Growth and Reputation***

  One of the most important priorities to anyone who works in healthcare, anyone who has ever needed care, and anyone who has walked through medical scenarios with loved ones (so, nearly all of us) is patient experience. For hospitals, having a dedicated inpatient provider team is the key to many patient experience initiatives. It allows for continuity of care through a centralized and limited number of people—which creates stability and clarity for both the patients and their families.

  With this continuity comes improved operational throughput, rigorous patient safety, and timely discharges to the next appropriate site of care (ideally, home)—again enhancing the patient's experience by providing the best care in the most efficient manner. Better patient flow throughout the hospital allows quick turnover to beds and growth in inpatient capacity. Ultimately, this positions the hospital to be the preferred facility in its community and to gain a larger share of patients.

- ***Quality and Clinical Outcomes***

  Along with improved patient experience, optimized length of stay and improved throughput are beneficial for the hospital's clinical and quality performance. The longer patients stay in the hospital, the higher their complication rates. A dedicated HM team has a solid grip on the right length and rigor of care that each type of patient needs and can develop best practices for healing their communities. In fact, research shows that higher numbers of hospitalists are associated with lower hospital readmission rates.[3]

  This team can also collaborate closely with other clinicians. HM providers can work with other departments to drive quality and safety initiatives (sepsis protocols, for example). They can build solid relationships and rhythms with the nurses on their floors. As a result, workflows become smoother, process compliance is enhanced, and resources are utilized more wisely.

- ***Financial Performance***

  In financial terms, reduced length of stay as a result of dedicated HM programs emerges as an important factor again. Keeping patients for only the appropriate amount of days translates to fewer unnecessary costs on the hospital. And, as mentioned earlier, readmission rates have also declined with the growth of hospitalists—improving hospital ratings and reimbursement.

  Having a consistent team of hospitalists also enables hospitals to invest wisely in clinical documentation improvement programs. Return on that investment is realized when more accurate coding and billing improves case mix index—again driving higher hospital ratings and reimbursement.

PATIENT PERSPECTIVE

The expected benefits of a dedicated HM program to the patient were explored within the provider and hospital sections, but to summarize:

- Regular and consistent visits from providers (rather than waiting on a community provider or on-call specialists to find available rounding time)
- Efficient movement through the admission, care, and discharge processes, enabling them to get home (or to the next site of care) at the right time
- Proven, best-practice treatments from providers who specialize in the care they need
- Lighter financial burden due to less unnecessary testing, fewer medications, and only staying the right number of days in the hospital

Now that we've illuminated the beneficial role HM plays in healthcare, let's take a look at the other side of the coin. There are still some important financial implications to be aware of when looking at HM programs.

ECONOMIC REALITIES OF HOSPITAL MEDICINE

First, the nature of the inpatient population tends to be primarily Medicare and Medicaid—with a much smaller portion of commercial patients. Unfortunately, due to the way CMS reimburses, hospitals usually find that:

It might sound initially discouraging that HM requires subsidization, but there is a compelling, quantifiable ROI associated with that investment. Let's run the scenario:

1. We take the average, 150-bed community hospital with around 60% occupancy and find average number of discharges per year
2. We juxtapose that against the industry average hospital medicine subsidies per provider FTE to see what it costs to cover those discharges
3. We use those numbers to find the average cost per day of the average inpatient stay
4. To see the effect of a dedicated HM program on costs, we reduce the number of average inpatient days by just half a day—12 hours
5. We find that ROI is about four to one on the subsidy investment (typically millions of dollars in improvements for an average-sized hospital).

If you're curious to learn more about these numbers, contact us at **business_development@scp-health.com** to discuss your thoughts.

The ROI calculation above only accounts for cost improvement opportunities. To take it a step further, length of stay reduction adds more effective inpatient bed capacity to the hospital which can also lead to significant volume and revenue growth.

Now knowing the benefits of a dedicated HM program, the clear question is: can those advantages truly be realized? In other words, is this qualitative and quantitative success really achievable? The answer is a resounding yes, but hospitals need the right framework, tools, and partnerships to get them there.

We've boiled our experiences and outcomes down into a clear hierarchy of needs for HM success. Each tier of the hierarchy includes its own set of building blocks that help hospitals evaluate where they stand—and blaze a path forward.

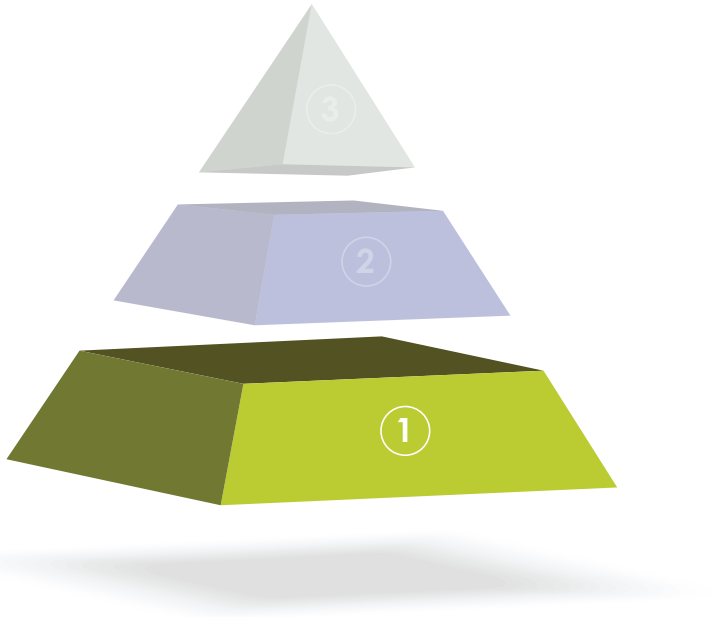
HOSPITAL MEDICINE HIERARCHY OF NEEDS: BUILDING BLOCKS FOR SUCCESS

Before introducing the framework, it's helpful to level-set. Unless we know an organization's particular economic situation, community dynamics, and other important factors, we cannot recommend an exact customized path to success. However, this hierarchy of needs sets forth best practices across the industry for growing HM capabilities and effectiveness.

TIER 3: ADVANCED

TIER 2: INTERMEDIATE

TIER 1: FOUNDATIONAL



HIERARCHY OF NEEDS TIER ONE: FOUNDATIONAL

Tier One represents what we call the "foundational" attributes of a high-functioning HM program, and is comprised of four capabilities: staffing to volume/acuity, documentation best practices, seamless handoffs, and care team leadership. Tier One is essential both because it contains important capabilities and because most capabilities of the next two tiers depend on Tier One's core components and effective execution.

STAFFING TO VOLUME/ACUITY

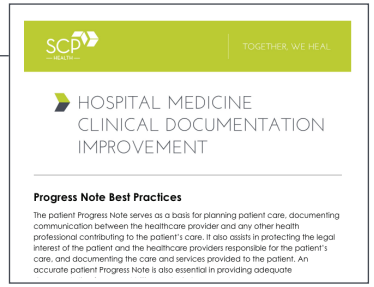
Hiring and scheduling the appropriate number of providers can be challenging and opinions on what is best vary widely; this is clear from just a brief glance at literature. Some studies have suggested that length of stay increases significantly when hospitalists care for more than 11 patients at a time.[5,6] A 2019 survey found that the number of patients per shift seen by hospitalists have remained the same for 10 years, at just under 16—and most hospitalists thought that around 15-16 was reasonable. That same survey reported that local hospitalist groups and national hospitalist management companies were seeing well over 17 patients per shift.[7] These variances can be driven by a wide variety of factors that are unique to each hospital, including the availability of additional resources such as consultants, residents, or scribes; the geography of the inpatient units; and coding expectations for the providers.

To determine the right number for their own HM practices, organizations should focus on the patterns of volume that the program is experiencing and the acuity of the patients they are admitting.

DOCUMENTATION BEST PRACTICES

Strong documentation is critical to HM because it improves reimbursement for physician and hospital billing. As seen in the equation earlier, subsidy is often needed to support the HM program—but better reimbursements will make the subsidy amount smaller. Continually educating providers on appropriate documentation best practices serves to increase wRVUs.

Excellent documentation practices also improve the hospital's case mix index (CMI)—and even small changes in CMI can dramatically increase hospital reimbursement. This piece is vital because it can ultimately allow the HM program to start paying for itself.


SCP HEALTH
TOGETHER, WE HEAL

HOSPITAL MEDICINE
CLINICAL DOCUMENTATION
IMPROVEMENT

Progress Note Best Practices

The patient Progress Note serves as a basis for planning patient care, documenting communication between the healthcare provider and any other health professional contributing to the patient's care. It also assists in protecting the legal interest of the patient and the healthcare providers responsible for the patient's care, and documenting the care and services provided to the patient. An accurate patient Progress Note is also essential in providing adequate

One way SCP Health focuses on documentation improvement is consistently sending helpful documentation tips to providers via email.

SEAMLESS HANDOFFS

Handoffs are unavoidable and completely necessary—but they don't have to be done constantly, and they can be done very well. If handoffs happen too frequently or ineffectively, studies have shown mortality and morbidity rates increase significantly. [8,9,10]

To have a strong foundation, both inter-team and intra-team handoffs need to be standardized and smoothed. Specific critical handoffs are: from EM to HM when the patient is admitted, between HM day shift providers and nocturnists, and between HM providers and other consulting specialists.

CARE TEAM LEADERSHIP

The HM team needs to be empowered to lead the entire care team and facilitate movement of the patient throughout the healthcare system—from admission to discharge. The HM provider manages the patient's care plan and coordinates consultants on the case. One expert called hospitalists the 'backbone' and the 'quarterback' of the patient's medical staff—holding all the pieces together, seeing the whole picture, enabling the care team to function effectively, and always bringing decisions back to the best interests of the patient.[1]

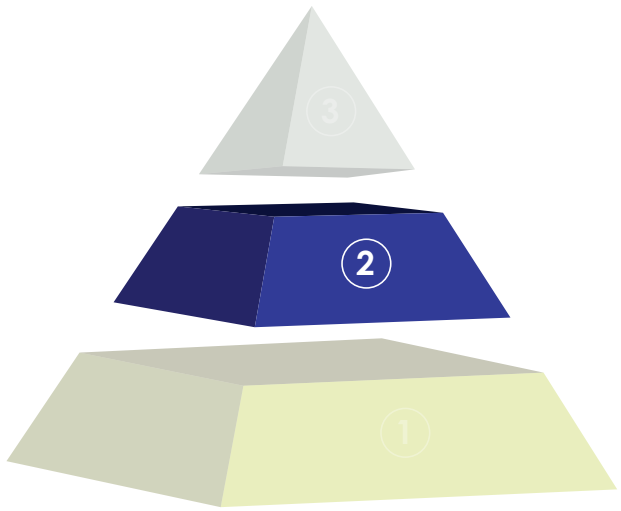
At SCP Health, we help our partner hospitals implement Joint Operations Committees (JOCs) to create bonds between specialties, identify areas for improvement, lay out action plans, and track progress.

JOINT OPERATIONS COMMITTEE 101

- What is a JOC?
- What are the benefits of establishing a JOC?
- How often should the JOC meet and what should be on the agenda?

EM AND HM SYNERGY IMPROVES LOS, READMISSIONS, AND PATIENT EXPERIENCE

- What does a JOC look like in real life?
- What kind of challenges have JOCs worked through?
- What type of results have come out of JOC processes?



HIERARCHY OF NEEDS TIER TWO: INTERMEDIATE

Tier Two represents what we call the "intermediate" characteristics of a high-functioning HM program. It is made up of four more priorities: optimized length of stay, multidisciplinary rounds and geographic rounding, improved patient experience, and leadership in hospital initiatives.

OPTIMIZED LENGTH OF STAY

Earlier sections of this paper made it quite clear how important length of stay is—and how much of an impact a dedicated HM program can have on that metric. Optimizing length of stay is accomplished in two main ways.

First, the patient's clinical acuity has to be correctly recorded—which is why documentation best practices are a tier one requirement. If the patient's condition is documented accurately, treatment needs and target length of stay can be determined appropriately.

Second, everyone participating in the patient's care needs to be aware of that expected length of stay so that they are all working toward that same goal. From case management to physical therapy, each member of the care team must understand what the goal is and what the steps are to accomplish it. These expectations and goals are often set during multi-disciplinary rounds (covered in the next section).

MULTIDISCIPLINARY ROUNDS AND GEOGRAPHIC ROUNDING

Multidisciplinary rounds is a practice of having the care team come together for rounds and discuss the patient's status and trajectory. This can start with just the provider and nurse, but the goal should be to continue adding team members (case management, PT, OT, nutrition, etc.) When done correctly and cohesively, this type of rounding will help build up two of the other aspects of Tier Two: patient experience and length of stay.

Geographic rounding limits the lead HM clinician to a localized geographic part of the hospital. With all their patients in one general area, the clinicians are able to spend more time with each patient and react more quickly to changes in patients' statuses. Just like multidisciplinary rounds, this practice of giving the provider a smaller physical footprint to cover enables length of stay to decrease and

patient experience to improve. It also improves provider satisfaction by giving them more time in their days and reducing the amount of unnecessary ground they have to cover.

LEADERSHIP IN HOSPITAL INITIATIVES

A brief look at the past 20-25 years of Hospital Medicine's life shows that hospitalists were fairly quickly viewed as resources who could champion important hospital initiatives, provide valuable feedback to administration, and be agents for meaningful, patient-oriented change.[1,11]

To build a high-functioning HM program, hospitalists have to fully embrace this important role. Hospitalists should have a seat on the medical executive committee, participate in or lead almost all hospital improvement committees, and be proactive in identifying issues and creating plans for change.

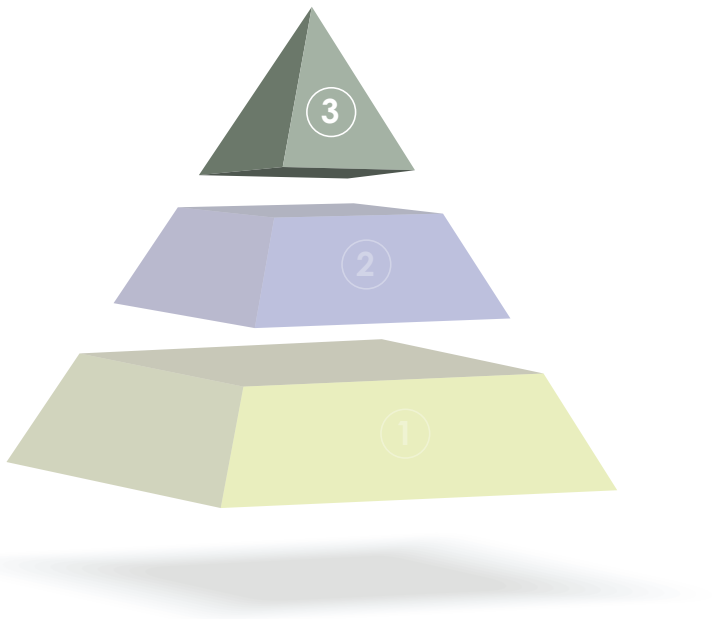
At SCP Health, we help our partner hospitals improve patient experience by training providers to enhance their communication abilities, prioritize patient and family convenience as much as possible in their decision making (e.g. round at a reasonable time), and practice self-care so they don't experience burnout. In short, we help our people take better care of people.

A W.I.S.E. APPROACH TO PATIENT SATISFACTION

- How to manage **W**ait times
- What **I**nformation to share with patients
- How to handle **S**ymptoms
- How to **E**xpress genuine concern

5 DRIVERS OF POSITIVE PATIENT SATISFACTION

- Which aspects of patient satisfaction can leaders and providers influence?
- How do you tap into the cycle of happy providers and happy patients?
- What financial benefits can be triggered by improved patient satisfaction?



HIERARCHY OF NEEDS TIER THREE: ADVANCED

Tier Three represents what we call the "advanced" characteristics of a high-functioning HM program. It is made up of three final capabilities: top-of-license NP/PA practice, use of technology to expand the care team, and post-discharge care coordination.

TOP-OF-LICENSE NP/PA PRACTICE

As mentioned earlier, the hospitalist is often called the 'quarterback' of the patient's clinical care. But in the words of Society of Hospital Medicine journalist Richard Quinn, "even the best QB needs a good team to succeed…that roster increasingly includes nurse practitioners (NPs) and physician assistants (PAs)."

Making NPs and PAs a key part of the hospitalist team is critical for ongoing success—especially due to the physician shortage and reimbursement declines. While the extent of autonomy allowed is dependent on state-by-state regulations, each hospital can benefit from incorporating the unique perspectives and skills of NPs and PAs into the HM team.

Be prepared to potentially change hospital bylaws to detail the expanded responsibility for NPs and PAs as well as the guidelines for recruiting, training, and supervision. Clinicians themselves may also need to shift their vision of how the care team functions, and could need training on best practices for working together most effectively.

USE OF TECHNOLOGY TO EXPAND THE CARE TEAM

While there are a lot of technological ideas and innovations we could explore here, the most important one for the purposes of a high-functioning HM team is telehealth. In smaller facilities, telemedicine capabilities can be used to cover nights when having a physician onsite is cost prohibitive.

It can also be used to cover daily, seasonal, or emergent surges. A key proof point here is the dramatic rise in dependence on telemedicine during COVID-19. Virtual care options enabled providers to safely screen and treat patients without further endangering the health of either group. Moving forward, these technology-enabled capabilities will be essential, not optional.

Finally, hospitalists can participate in telemedicine to provide other medical care directly to outpatients in the community when/if they have available capacity, or to help with continuity of care initiatives. This option is convenient and cost-effective for the patient, which in turn is beneficial for the hospital's reputation and reach.[12]

POST-DISCHARGE CARE COORDINATION

In that same vein of reaching patients outside of the hospital, the final key component of a Tier Three HM program is post-discharge care coordination. This is critical for patient success and is also becoming increasingly more important for hospital success as quality programs and pay-for-performance expand.

The first step is identifying the appropriate next site of care for each patient. Start by asking 'why not home?' and, if that option is not safe, work through the levels of care from least to most intensive in order to find the right place. When possible, proactively team with care providers outside the hospital (home health agencies, SNFs, etc).[1] This establishes healthy working relationships and helps ensure continued quality and accuracy of care for your discharged patients.

The next step is following up on those patients to ensure continued health and decrease the chance of readmission. This includes confirming that all patients are scheduled for a primary care appointment within 72 hours of discharge, staffing a post-discharge clinic for patients who don't have a PCP or can't see one in a timely manner, and collaborating with EM colleagues so that no patient is readmitted without the HM team (who initially treated that patient) having the chance to evaluate and discuss with the EM team.

At SCP Health, we help our partner hospitals go beyond the four walls of the hospital. We deploy direct-to-employer programs to connect with the commercially insured community; provide non-clinical inbound and outbound patient navigation services; and execute clinical care coordination in the form of Transitional Care Management, fielding inbound medical questions and guiding the patients' transition to home, home health, or the next care facility.

HOW TO REACH BEYOND THE FOUR WALLS OF THE HOSPITAL

- Why is going 'beyond the four walls' an increasing priority?
- What are the benefits to a facility or health system of investing in patient care this way?
- Why isn't everyone doing this already, and what's the first step to get started?

UTILIZING DIRECT-TO-EMPLOYER MARKETING AND PATIENT NAVIGATION TO ENGAGE A NEW PATIENT POPULATION

- What does a focus on patient engagement in the community look like in real life?
- What is the financial impact of these efforts?

FROM PRINCIPLE TO PRACTICE

While tactics make sense on paper, it can be difficult to get started and actually execute on them. Though some organizations successfully build advanced HM programs on their own, most will require more support and guidance. The following two case studies bring the Hierarchy of Needs to life and demonstrate how a partner like SCP Health can help hospitals accomplish their goals efficiently and effectively.

CASE STUDY: BUILDING A REPUTATION OF QUALITY PERFORMANCE

A 138-bed facility was struggling with length of stay and quality metrics in both their HM and Critical Care programs. After being chosen to partner with this facility, SCP ensured that the staffing was appropriate for the volume and acuity of patients and began educating the teams on documentation strategies to capture all the work that was being done (both Tier One capabilities).

SCP also initiated leadership meetings (a JOC, as discussed in Tier One) that brought EM, HM, and ICU leadership together with the hospital's executive team and frontline providers to work toward quality improvement. Finally, SCP implemented geographic rounding for the HM team and started a mega-huddle (type of multidisciplinary round, as discussed in Tier Two) to address specific patients with discharge barriers.

IN JUST SIX MONTHS, THIS FACILITY WAS ABLE TO ACHIEVE THE FOLLOWING RESULTS:

EXCESS DAYS PER PATIENT, HOSPITAL-WIDE DECREASED FROM

.87 TO .16 DAYS

ICU WRVU PER ENCOUNTER INCREASED FROM

3.43 TO 3.70

LOS, HOSPITAL-WIDE DECREASED FROM

4.64 TO 3.99 DAYS

From a dollars and cents perspective, in that short time the **reduction in LOS saved about $2.9 million** and the ICU's **documentation improvement efforts saved approximately $19,000.**

CASE STUDY: HM TRANSFORMATION YIELDS SIGNIFICANT RESULTS

A 200-bed facility was faced with high length of stay and ineffective admission and consulting practices.

SCP Health stepped in to help this facility optimize staffing, including hiring and integrating NPs and PAs (as discussed in Tier Three), to manage the actual number of patients on the census and empower the HM providers to take on their role as quarterback (as discussed in Tier One). This quickly freed up the beds necessary to release ED holds and keep patients from leaving without treatment or transferring to another hospital.

SCP also delivered provider education on appropriate admission and consulting processes, and documentation improvement (as discussed in Tier One). Finally, SCP empowered the HM providers and managers to lead initiatives focused on optimizing length of stay and throughput (as discussed in Tier Two).

IN ONLY FIVE MONTHS, THE FACILITY SAW THE FOLLOWING IMPROVEMENTS:

INAPPROPRIATE CONSULTS AND ADMISSIONS: ALMOST ENTIRELY ELIMINATED IN JUST

3 DAYS

DECREASED DENIALS

WRVU: IMPROVED FROM

1.94 TO 2.05

WITHIN FIRST FIVE MONTHS OF PARTNERSHIP

LOS, HOSPITAL-WIDE: DECREASED FROM

6.4 TO 4.8 DAYS

WITHIN FIRST FIVE MONTHS OF PARTNERSHIP

In terms of financial benefits, this quick HM transformation brought a **reduction in LOS that saved about $4.8 million and an increase in wRVU that earned $88,000**.

NAVIGATING THE ROAD AHEAD

There are many directions that the future of healthcare could go—and organizations almost certainly cannot be prepared for every possible challenge and opportunity. But there are key ideas that hospitals and health systems should consider as they venture into the future of inpatient care.

PATIENT EXPERIENCE

Evolve the focus from episodic patient satisfaction scores to longitudinal patient loyalty. This involves thinking about all the bumps and barriers that patients encounter when interacting with the hospital—before, during, and after admission.

Consider the following:

- how patients are interacting with hospital services and representatives in the community
- where they are located and how they transport themselves
- what they know about how to navigate the revenue cycle process
- how they access their health information
- what their jobs demand physically and emotionally (or how they cope if they lack jobs)
- who comprises (or is missing from) their support systems
- what they might be struggling with that could affect their health journey

All of these questions (and more) are important to answer because they have a distinct impact on patient outcomes, population health, and

the success of hospital initiatives. Prioritizing patients to this extent can require a widespread culture change, new or revised positions within the hospital, and working with external partners to help structure and deploy these efforts.

SCHEDULING MODELS

The HM model has evolved to primarily use 12-hour shifts with seven days on and seven days off for providers. While this model has it benefits, it also has some unfavorable side effects—and may need to be revised.

From a capacity perspective, the traditional scheduling model is too static. It is not responsive to unexpected daily or monthly changes and cannot flex to fit typical hospital volume patterns. With margins as tight as they are, hospitals cannot afford to bring on extra providers who may only be needed for the relatively brief increments where it is too busy for the normally scheduled providers to safely manage. On the flip side, hospitals cannot afford to find themselves regularly understaffed, as this builds up inefficiencies that result in patients leaving without treatment, transferring out, or staying too many days.

Changes to this model could happen in a number of ways, but two technology-enabled examples are:

- using supplemental telemedicine coverage to augment onsite HM providers during surge periods
- allowing hospitalists to re-deploy excess time during slow periods by taking virtual visits

Be innovative here and think outside the box. For example, consider offering virtual sports physicals at schools during the day—this creates ease for the patient and family, while also using your providers' time wisely.

VALUE-BASED CARE

HM teams must be focused on how to get patients on the best track for successful recovery. Set your organization up to be successful over the course of 90-day bundles, or other value-based care arrangements as they continue to grow in our market. These programs are—and will increasingly become—critical to helping sustainably fund a dedicated HM program.

TECHNOLOGICAL INNOVATION

In order to be an innovative organization, be willing to think differently. This **does not** mean thoughtlessly investing in any new gadget or trick that emerges in the market. It **does** mean evaluating the hospital's goals, soliciting input from various employees within the organization, and looking at the greater community's needs when evaluating and choosing what technology to implement.

Consumers of all ages adjusted to and became comfortable with a virtual life as a result of the COVID-19 pandemic. Though virtual health was already on the rise, it is now an imperative for hospitals and health systems as they adjust to their patients' new priorities. Offering accessible, affordable, and socially-distanced care options will significantly help hospitals rebuild consumers' trust and loyalty, provide care when and where patients need it, and promote improved health throughout their communities.

While we believe that telemedicine capabilities are essential, hospitals should also consider the possible benefits of artificial intelligence, big data, natural language processing, blockchain, and more.

ROLE OF THE HOSPITALIST

As the specialty of HM continues to mature, there must be a discussion about how the increasing responsibilities of the department changes the role of the physician as well.

Given the existing role of quarterback, hospitalists have a good view into the processes of and interactions between other specialties within the hospital. As more care starts to take place outside the hospital, the provider has to be able to flex those QB muscles with external contacts.[13] The hospitalist is critical to forming positive and sustainable partnerships with other members of the medical staff, primary care physicians in the community, local post-acute care providers, and community organizations; creating loyalty among the patient population; and bolstering the reputation of the hospital with patients and other providers along the care continuum.

While we've discussed the importance of hospitalists leading the charge on quality, safety, and experience initiatives, they should also be on the front lines of technological advancement in decision-making and implementation. To again quote the Society of Hospital Medicine, "they need to continue to master technology, clinical care, and the ever-growing importance of where those two intersect."[1] This includes being proactive in pursuing the training and developing the skills needed to understand the industry's innovation landscape and provide care in new, technology-enabled ways.[13,14]

Finally, hospitalists must be active participants in the industry-wide drive to reduce and avoid provider burnout. This means personally adopting self-care and stress-relieving habits, mentoring the next generation of hospitalists in healthy practices, and being leaders in the organization to call out and change any patterns or pressures that place unnecessary burden on the care team.

LEARN MORE FROM SCP HEALTH

Which Tier Does Your HM Program Fit Into?

- Tool: Hospital Medicine Program Development Diagnostic

Tier One Resources

- Blog: 'Think with Your Ink': 4 Reasons Why Proper Medical Record Documentation Is Vital
- Case Study: Unified Hospital, Emergency, and Urgent Care Teams Improve Access and Metrics
- Tool: 20 Key Questions to Align your EM and HM Teams

Tier Two Resources

- White Paper: The Lifetime Value of Patient Loyalty
- Blog: 4 Ways to Foster Better Doctor-Patient Communication and Improve Patient Satisfaction
- Case Study: Improving Hospital Medicine Metrics and Collaboration Between Facilities

Tier Three Resources

- Infographic: 6 Benefits Telemedicine Brings to Your Hospital Medicine Program
- Blog: Telehealth Readiness Factors: What Are They and Why Are They Essential?
- Blog: Leveraging NPs and PAs to Maximize Success in Hospital Medicine Programs
- Case Study: Diversifying Provider Teams to Improve Key Metrics

References

1. https://www.the-hospitalist.org/hospitalist/article/121525/hm-turns-20-look-evolution-hospital-medicine
2. https://mfprac.com/web2019/07literature/literature/Misc/Hospitalist_Wachter.pdf
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5804680/
4. https://www.medscape.com/slideshow/2019-compensation-hospitalist-6011429
5. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1847571
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3200101/pdf/i1552-5775-15-3-51.pdf
7. https://www.todayshospitalist.com/trends-patient-volumes-hospitalists/
8. https://jamanetwork.com/journals/jama/fullarticle/2589342
9. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_(1).pdf?db=web&hash=5642D63C1A5017BD214701514DA00139
10. https://www.journalofhospitalmedicine.com/jhospmed/article/126815/handoffs-ed-inpatient-care
11. https://www.the-hospitalist.org/hospitalist/article/122967/hospital-medicine-where-weve-been-and-where-were-going
12. https://www.hospitalmedicine.org/globalassets/practice-management/practice-management-pdf/shm---telemedicine-white-paper.pdf
13. https://www.the-hospitalist.org/hospitalist/article/172614/leadership-training/crystal-ball-future-hospital-medicine
14. https://www.journalofhospitalmedicine.com/jhospmed/article/175073/hospital-medicine/virtual-hospitalist-future-now

SCP Health (SCP) is a clinical company. At our core we work to bring hospitals and healers together in the pursuit of clinical effectiveness. With a portfolio of over 8 million patients, 7500 providers, 30 states, and 400 healthcare facilities, SCP Health is a leader in clinical practice management spanning the entire continuum of care, including emergency medicine, hospital medicine, wellness, telemedicine, intensive care, and ambulatory care.

Want to learn more about how we can take your hospital performance to the next level?

Contact us at:
business_development@scp-health.com or visit scp-health.com.

SCP HEALTH

TOGETHER, WE HEAL