Q&A: THE NEXT GENERATION OF HOSPITAL MEDICINE

OUR ANSWERS TO EXECUTIVES' COMMON QUESTIONS:

1 How is telemedicine being leveraged most effectively in Hospital Medicine (HM)?

First, consider using telemedicine for night coverage if your census doesn't justify the expense of a full-time, onsite provider. This use of telemedicine for night coverage also relieves a burden for dayshift providers – you won't have to put them on call for another 12 hours after their 12-hour shift.

Second, consider rolling out telemedicine into the daytime to cover surges. Surges can be patterned (certain days per week or months of the year) or can be more random (accidents, pandemics, etc)—and telemedicine services can help in both cases.

Lastly, telemedicine is effective when used to manage other instances when coverage is challenging, included extended time away (maternity leave, lengthy holiday travel), admission, medical consults, and more.

At SCP Health specifically, we staff eHospitalist services for all the scenarios detailed above.

2 What are the best practices for utilizing NPs/PAs in HM?

It is critical to use NPs and PAs at the top of their license. Though their scope will be largely determined by state guidelines, often they will be able to carry their own panel of patients or provide care for certain diagnoses.

There are two highly important practices here. First, make sure the hospital bylaws and continuing education programs are updated so they align with the way that you want NPs and PAs to be able to function. Second, build a structured program that dictates how frequently and comprehensively the NPs and PAs communicate with the supervising physician—and how often the physician sees the patient as well.

3 How can we improve our wRVUs, and what is a good wRVU benchmark number that our HM providers can work toward?

At SCP Health, our average wRVU per patient encounter is 2.2 for HM providers. This number can be used as a goal for programs no matter what their level of development is. The most important factors for improvement are excellent documentation education and practices, central coding of all charts, and regular audit, review, and feedback cycles.

4 How should hospitalists function within, and collaborate with, the rest of the hospital's clinical staff?

In terms of the clinical team's structure, not much should change with the introduction of hospitalists, other than primary care physicians not needing to come into the hospital to round.

When we think of inter-specialty communication and collaboration, this can be more difficult and is an area on which we focus heavily at SCP Health. We often see challenges arise between Emergency Medicine (EM) and Hospital Medicine providers when they are not on the same page or working together as a cohesive team.

To address that, first determine whether both teams have the same set of properly aligned goals. This coordination ensures that resources and energy are spent effectively toward objectives that will make a difference for both specialties (and hospital-wide). This relationship-building and goal setting should occur in regular, planned meetings of leaders and providers from both EM and HM. Our SCP Health team calls this a 'Joint Operations Committee.' Beyond that, the medical directors of EM and HM should also be consistently meeting every couple of weeks to discuss challenges and issues in a safe environment.

Secondly, lay out 'rules of engagement' in advance of particular situations. For instance, if you're faced with a specific diagnosis, have a playbook of what tests need to be available before admission, who needs to be a part of that patient's care team from the start, etc.

Lastly, encourage the EM and HM teams to socialize outside of work—whenever possible. When you've broken bread with someone and gotten to know them, it's a lot easier to assume the best of their intentions and actions. Get people together and create a culture that strengthens bonds and resilience.