A NEW Hospital Medicine Equation for a Post-COVID Future

Evolving the quality-cost value equation, optimizing inpatient care delivery

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Introduction

Hospital medicine (HM) was born out of a chaotic time in U.S. health care, in response to clear hospital needs. The 1990s saw the swift growth of managed care coupled with an influx of unassigned patients requiring inpatient admissions. In response, hospitals sought agile generalists who could care for these complex patients.

Amidst early growth in hospital medicine, Dr. Robert Wachter defined the value equation that would provide the framework for both how hospitalist leaders managed their own practice, and how hospital executives evaluated their hospital medicine program.

I remember because I was there, a participant, in one of the very first meetings of the newly born National Association of Inpatient Physicians. There, Dr. Wachter defined the hospital medicine value equation as a product of its quality divided by its cost.[1]

Fast forward 25 years, and as physicians, we have now endured another chaotic time in U.S. health care:

- A dramatic, COVID-induced exiting of clinicians from the workforce
- A rise in inpatient acuity combined with geographically disparate surges in volume
- Increased pressure on reimbursement, especially for hospitals dependent on Medicare rates

Today, these combined challenges are forcing an evolution in inpatient hospital care. Hospitals need a new answer to the familiar problems of how to provide 24/7 quality care to patients while maintaining financial solvency. Many hospitals are struggling to deliver that, and yet patients across the country are depending on them more than ever to do so.

A strategic solution to these challenges can be found by once again leveraging the historical strengths of the agile hospitalist, while also evolving the equation for hospital medicine care delivery and deploying a new quality-cost value equation.

The result of this new quality-cost value equation for hospital medicine will allow hospitals not just to survive this chaotic time, but to increase and improve care to their communities. By fractionating the needs of an inpatient hospital program into its constituent parts, and then integrating them into a greater whole, we can evolve the quality-cost value equation across the health system ecosystem. This advancement is necessary and beneficial for all in the health care ecosystem including health systems, clinicians, and patients.

This paper will outline methods for taking a deeper look at the component parts of a strong hospital medicine program, while also providing a framework for evolving toward a new equation, implementing innovative programs to increase the quality side, while deploying risk sharing on the cost side of the equation.

1. The Evolution of Hospital Medicine

It was 1996 when Dr. Wachter, writing in the New England Journal of Medicine along with Dr. Lee Goldman, first termed the new hospital-based physicians "hospitalists."[1] In doing so, they gave this new role much needed legitimacy, and thus, a new medical specialty was born.

In those early days, the hospital medicine value proposition was focused on management of the "unassigned patient"—those patients requiring admission from the emergency department without an assigned primary care physician. Thus, hospital medicine took root, born from its slightly older professional sibling, emergency medicine (EM).

Many of us practicing at that time can vividly remember the controversy surrounding the emergence of the hospitalist, with numerous primary care colleagues lamenting their replacement in the inpatient setting and onlookers doubting the viability of this new trend. Most notably, the intense debate regarding the sustainability of a new specialty with such a dramatic gap between physician compensation and professional fee reimbursement seemed to be a formula for failure.

But, hospital medicine not only took root, it also went on to completely transform the model of care delivery to the country's inpatients.

Early hospital medicine value focused on improvements in quality such as inpatient quality management including PQRS, inpatient mortality, patient, nurse and medical staff satisfaction, and the intangibles of enhancing primary care physician lifestyle and medical staff recruitment.

Hospital medicine also focused on incorporating quantitative improvements in efficiency, measured by length of stay and ED throughput, utilization cost per case, and revenue enhancements through documentation improvements including case mix index. Hospitals required all these tactics to survive financially in the managed care era.

Meanwhile, hospital medicine's contemporaneous alignment with the Institute of Medicine's "To Err is Human" and the resulting patient safety movement further served to solidify the hospitalist's position.

From the "round and go equation" of the early years to the "24/7 shift-based equation" that became a standard of care, Hospital Medicine mirrored the structural evolution of emergency medicine.

Throughout these evolutions, hospitalists demonstrated agility, a capacity for change, broad perspectives, and consistent leadership. Hospitalists adapted to the changing environment, evolving the equations for hospital medicine, while continuing to advance patient care in the most challenging of circumstances.

2. The Quality Side: COVID and Its Effect on Hospital Medicine

The COVID-19 pandemic injected new challenges for hospitalists and drove changes to the quality side of the value equation. The pandemic forced movement from the traditional practice management efficiencies to a greater focus on critical care procedure competencies.

Historically, the role of hospitalists evolved over time to serve as the "quarterbacks" of inpatient care. From managing throughput, to accepting expanded responsibilities for quality performance, patient satisfaction, and patient safety initiatives, hospitalists have become broad clinical leaders within the inpatient hospital environment.

Amidst the pandemic, new requirements for hospitalists emerged. Those with expertise in critical care were called upon to manage the complex, high-acuity patients. In addition, hospitalists and their care teams adapted to unprecedented, non-uniform, and difficult-to-predict surges in inpatient volumes, along with nursing and support staffing shortages, which accelerated challenges with burnout.

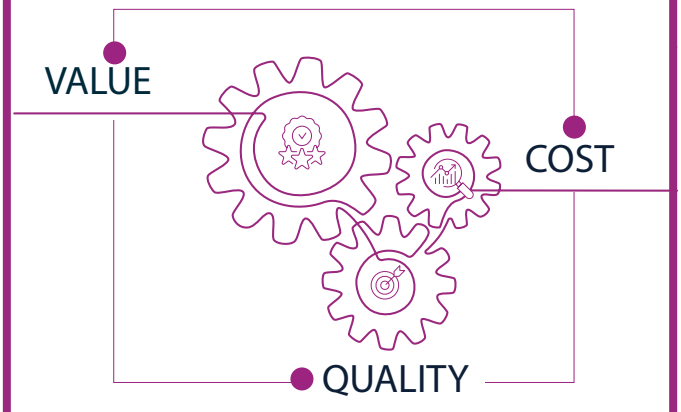
And yet, despite these challenges, hospitalists have once again demonstrated agile leadership in their roles by focusing on adapting to the ever-changing environment to ensure quality care. The shift towards balancing efficiency with quality will be part of the new normal for hospital medicine and creates new opportunities for hospitalists to again lead change within their environments and demonstrate the quality and value delivered by a strong hospital medicine program.

3. The Cost Side: Coverage and Telemedicine

The COVID-19 pandemic introduced many new care and quality imperatives, but nothing as profound as the need to quickly adjust staffing for the multiple waves of surges in patient volume. The pandemic fundamentally impacted the cost side of the value equation, and as a result, health systems were forced to find innovative methods for managing clinical resources across surging caseloads. Hospital medicine programs proved to be a critical strategic and tactical component to address inpatient care coverage.

Hospital medicine telemedicine capabilities stepped into the limelight in a way that would have been thought unprecedented before March 2020. Medicine already had experience with leveraging telemedicine to expand access to specialty care—notably in telestroke programs that supported emergency medicine—but the pandemic forced all of U.S. health care to grapple with just how much care suddenly and quickly could be moved into a virtual environment.

Leveraging hospitalists with telemedicine technologies provides options for managing surge and shortages, while also improving the cost element of the value equation.



4. Reimagining Value: Downstream Impacts

Looking forward, there are clearly untapped opportunities to impact quality and cost components of the value equation. By maturing hospital medicine programs beyond our well-established foundations, hospital medicine can further impact quality, assist hospitals in managing cost constraints, and provide new levels of professional sustainability for the specialty.

Improving Quality

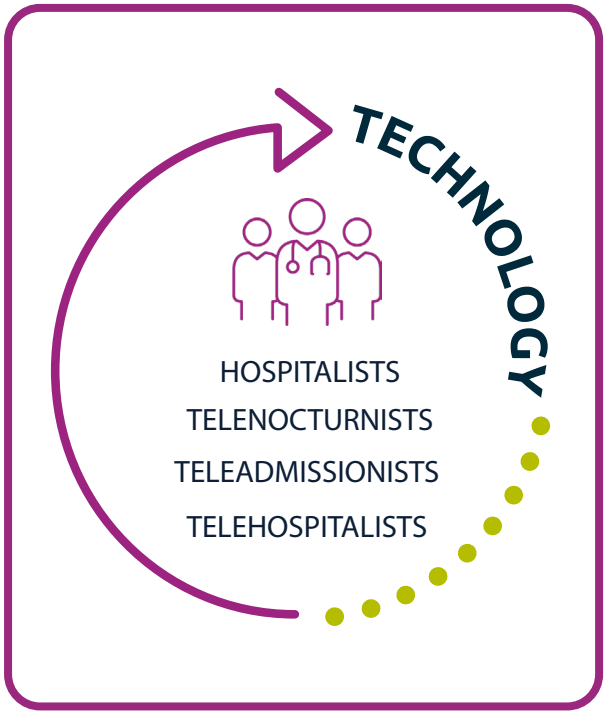
We can evolve the quality side of the equation by adopting two critical strategies: clinical focus on metrics and supporting the full patient journey.

- *Clinical Focus on Metrics*

While treating the patient in front of them, hospitalists can focus on their role in achieving high performance on the quality metrics of the facility, whether it be mortality and sepsis metrics, MIPS requirements, HCAHPS or other for value-based initiatives.

The quality metrics of a tertiary facility that is part of a national chain may be different than for a small rural hospital. Regardless, the hospitalist team must be able to acknowledge the customized quality needs of the facilities and translate quality into an executed process, successful in achieving the goals. Achievement of these quality goals is critical to assurance of CMS performance expectations and avoiding financial penalties and withholds.

The most under-valued tactic in this area of the hospitalist arsenal is the dedicated, so-called "non-productive" time of clinical leadership to address and support the management of these quality metrics. Non-direct patient care time is critical to developing care pathways, algorithms, and collaborative processes with facility staff so that the metrics which are indicators of quality patient care can truly be improved.



- *Supporting the Full Patient Journey*

The hospitalist can support smooth patient transitions to ensure continuance of quality care. In 2018, The Centers for Medicare and Medicaid Services introduced a new alternative payment equation, Bundled Payment for Care Improvement Advanced (BPCI Advanced), which effectively extended the fiscal responsibility for inpatient care providers to 90-days post discharge for all episodes.

This is a sea change in the traditional hospital medicine mindset, in which responsibility ended at discharge. In that time, hospitalists would admit and care for patients and see them through their hospital-based episode of care. But that care ended when the patient was discharged. However, in a programmatic approach that foreshadows the future direction of hospital medicine, hospitalists are already responsible not just for the care they provide to patients while they are admitted, but also for the 90-days post-acute continuum, as per BPCI Advanced. The bundling of the 90-days post-discharge, with attribution sourced to the hospital medicine physician, creates a new level of integration and coordination between the hospital medicine program and the next sites of care, with laser focus on readmission prevention.

The post-acute care journey is now squarely within the hospitalist's purview. This includes identifying the appropriate next site of care for each patient and proactively teaming up with other care providers. This could include care coordination with external resources such as Skilled Nursing Facilities (SNFs), hospital at home programs, primary care offices, or communicating with home health resources, family caregivers, or home nursing aids to support adherence to care plans.

Reducing Cost

We can also evolve the cost side of the equation by renewing focus in several areas including the expanding physician-led teams, ensuring throughput optimization, and advancing telemedicine.

- *Expanding Physician-Led Teams*

Since the beginning of hospital medicine, advanced practice providers (APPs) have been critical to expanding physician reach. With continued cost pressure, as well as post-COVID physician demand, APPs remain a valuable part of the hospital medicine care teams.

With the inclusion of APPs both in clinical and non-clinical roles, the care team can manage larger patient panels with more flexibility for changes in acuity and meeting discharge timelines. Challenges to APP integration continue to surround local medical staff cultures and facility by-law restrictions.

- *Ensuring Throughput Optimization*

There is no question that one of the driving pressures of the past two decades in hospital medicine has been the imperative to manage throughput more efficiently. Hospitalists must continue this primary focus.

First, the skyrocketing of ED hold times seen during the pandemic brought a new requirement for the EM and HM teams to not only work more collaboratively, but also be viewed as a single team. From the development of admission protocols to the ED dedicated hospitalist and HM "admitter" shifts, as well as the regular cadence of EM and HM leaders meeting to discuss bottlenecks and process flow, all are tactics to facilitate keeping the front door to the hospital open to capacity needs.

The integration of these two teams also remains essential for optimizing quality outcomes, including sepsis and antibiotic administration, as well as mortality with early discussion of advanced directives.

Second, the post-COVID hospitalist is critical to managing the continuum of inpatient care. From the morning sign-in/out of the nocturnist (be they onsite or virtual) for new admissions and change in status, to the morning multi-disciplinary rounding with all participants in the transitions of care (nursing, case management, SNF or swing bed, hospice, inpatient rehab, home health, etc.), assuring discharge orders by 11:00 am, the identification and prioritization of tomorrow's discharges, afternoon barrier rounds to further identify root causes of discharge failures, to telemetry and stepdown assignments, hospitalists continue to re-define inpatient process improvement.

- *Integrating Telenocturnists*

Pre-pandemic, telehospitalist programs were primarily used to supplement nighttime and weekend coverage in facilities where the patient volume would not support on-site physician coverage expense. The goal then, as now, is to help communities and rural hospitals ensure 24/7 coverage for its inpatient population while reducing burnout and overwork for the physicians providing the care.

During the COVID surges, hospitalists were frequently faced with a patient census that would double or sometimes triple in a matter of a few days, or even overnight. Additionally, and especially prior to vaccination availability, many hospitalists found themselves on the sideline with their own COVID infections and exposures.

Post-pandemic, the hospital medicine programs can leverage the telenocturnist role to handle these surges in volume, not just for COVID, but for any significant and unexpected change.

- *Adopting Teleadmissionists*

Surges in volume revealed the need, at times, for a dedicated teleadmissionist—a physician who can work across multiple facilities to smooth the admissions process. By reimagining the role, this can be available 24/7, yet only actually provided and paid for when necessary.

During and post the pandemic, with the telemedicine cart stationed in the emergency room, patients were afforded immediate access to the admitting hospitalist. The other on-site hospitalist partners are afforded uninterrupted attention to patient rounding, throughput management, and family and staff conferences. This backdrop of on-demand coverage can then be turned on or off as patient volume requires.

In lieu of scrambling for an additional four to six hours of onsite physician surge coverage during high admitting times and the need to decongest the emergency department, the hospitalist team would just divert new admissions to the teleadmissionist. In its most refined form, the 24/7 backdrop of teleadmissionist can eliminate the need for on-site swing shifts, as well as enhance productivity of the on-site nocturnist by providing cross coverage call support.

Post-pandemic, the teleadmissionist replaces the requirement for hospitalists to be on call in case of higher volumes, and thus will increase the satisfaction of the existing hospital medicine staff. Optimizing these on-call responsibilities will have a meaningful impact on reducing burnout and increasing clinical retention.

- *Deploying Telehospitalists*

Telemedicine technology has advanced to allow a telehospitalist to be a successful substitute for on-site physician presence, from remote daytime rounding to post-discharge televisits for readmission avoidance.

Not only was telemedicine quickly adopted, but in many cases, it became the platform of choice for patients looking to receive care without the threat of COVID exposure in a physician's office. The sophistication of plug-in diagnostics, advances in hardware and software, and enhanced video capabilities all support the extension of the physician behind the screen to the bedside.

5. Vision for the Future

During the COVID-19 pandemic, the pressures on hospitalists created new demands and challenges. The one constant over the past 25 years has been the agility of hospitalists amidst the changing health care landscape.

Hospitalists of the future will continue to be leaders within hospital environments. By evolving the quality-and-cost value equation, hospital medicine programs will provide strategic solutions to address hospitals' biggest challenges.

The newly evolved equation for hospital medicine may be adopted by hospitals today for immediate impact. With a renewed focus on clinical metrics and supporting the full patient journey, we can advance the quality side of the equation. By expanding physician-led teams, ensuring throughput optimization, and incorporating telemedicine, we can address the cost side of the equation.

Hospital medicine programs will drive ongoing throughput, with higher quality care, at a lower cost, in an agile manner, for hospitals to stay efficient no matter what crisis next arises.
No one can say for sure what the next quarter century of hospital medicine will hold, but there is confidence that hospitalists and hospital medicine can evolve and rise to the occasion.

SCAN ME

1 - Wachter, R. M., & Goldman, L. (1996). The Emerging Role of "Hospitalists" in the American Health Care System. New England Journal of Medicine, 335(7), 514–517.