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The
**Hospitalist
Program
Management
Guide**

SECOND EDITION

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Hospitalist program data

KENNETH G. SIMONE, DO

The hospitalist movement has flourished in the past decade. The medical profession and health-care industry are increasingly entrusting the future of hospital-based care to these practitioners. The value hospitalists bring to individual hospitals, patients, and fellow physicians cannot be overstated. Hospitalists have been called upon to help decrease the overall cost of medical care in the United States while improving patient access, patient care, and patient safety.

Although the specialty is still in its infancy, it is clear that hospitalists have impacted health-care in a positive way. Hospitalists serve as faculty or provide coverage for residency teaching programs, improve physicians' job satisfaction and lifestyle, and alleviate pressures created by the physician work force shortage.

Hospitalists are also assuming leadership positions within their respective institutions and within the national healthcare community. These practitioners are essential members of the integrated healthcare delivery team, and in many instances, they are the healthcare executive leaders on the national level.

The challenge facing hospitalist program leaders is collecting, documenting, and disseminating data that demonstrates the value the hospitalist team brings to the institution. Clinical data that verifies quality patient care and successful clinical outcomes is essential for many reasons, not the least of which is compliance with the Centers for Medicare & Medicaid Services' (CMS) pay-for-performance initiative and Joint Commission standards.

Hospitalist functions

Hospitalists' multiple and varied responsibilities provide both clinical and financial value to the hospital. The added-value services include:

- Developing and implementing evidence-based clinical guidelines
- Championing medication reconciliation initiatives
- Delivering quality patient care and quality outcomes
- Participating in patient safety initiatives
- Improving patient satisfaction

Hospitalists benefit the hospital financially by:

- Increasing provider productivity
- Decreasing patients' length of stay
- Ensuring proper resource utilization
- Decreasing the cost per case
- Decreasing the 30-day readmission rate

The successful execution of the aforementioned functions provides the hospital with an overall positive return on investment. However, some hospitalist functions are more difficult to measure directly but also benefit the institution. These less tangible functions include:

- Addressing hospital throughput issues such as expeditious movement of patients from the emergency department (ED) to the hospital wards
- Appropriately transferring patients from the intensive care or post-surgical units to the general medical floor
- Early discharge planning
- Admission of unassigned ED patients

- Around-the-clock in-house hospital coverage
- Participation in rapid response and code blue teams

A hospitalist provides value to the institution every time he or she serves on a medical staff committee, as an attending physician (or providing coverage) for residency teaching programs, or as an educator for the nonphysician hospital staff. An often overlooked added-value function provided by hospitalists is their indirect and direct involvement in recruitment, retention, and stabilization of the medical and nursing staffs. Finally, hospitalists provide value to the medical staff and hospital by serving in hospital leadership roles.

The healthcare stakeholders

The services provided by hospitalists affect patients, the medical staff, the nonphysician hospital staff, faculty and residents at teaching hospitals, insurers, hospital administration, accrediting agencies (e.g., state regulatory agencies, The Joint Commission, etc.), and external healthcare agencies (e.g., nursing homes, acute rehabilitation centers, home health agencies, etc.). These stakeholders require objective measurement of hospitalist performance, which can be gathered using quality and/or financial metrics and customer satisfaction data. Keep in mind that the hospitalists' "customers" include patients, primary care physicians, specialist physicians (medical and surgical), and the nursing staff.

The remainder of this chapter will explore these quality metrics and discuss their relevance.

The hospitalist scorecard or dashboard

Most hospitalist programs require a financial subsidy to effectively carry out their clinical and administrative responsibilities. To justify receipt of such a subsidy, a hospitalist program must demonstrate its clinical and financial value in a measurable manner.

The institution that directly benefits from the hospitalist program typically provides the subsidy because many of the functions performed by hospitalists are not directly measurable and are not eligible for reimbursement. Other sources of subsidy include:

- Insurers (in a true managed care environment)

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- Physicians utilizing the hospitalist services
- Regulatory agencies

To demonstrate value, hospitalist programs must obtain accurate, accessible, comprehensive, reproducible, and timely data. Once this data is collected, the hospitalist program should consider developing a performance scorecard to display that data. A hospitalist performance scorecard or dashboard is a valuable tool for gathering and analyzing vital hospitalist financial and clinical data. The most successful hospitalist programs take the scorecard one step further and use it to improve patient care, deliver successful clinical outcomes, and advance the program's goals. Proper analysis and application of the data may also ensure long-term financial viability for the hospitalist program and the institution it serves.

The hospitalist program should obtain performance data monthly, quarterly, and annually and compare that data to the previously collected data. It is preferable that current data is compared with historical data collected over three to five years. The hospitalist program should also present the information in a year-to-date format. The program should gather individual provider data as well as data for the entire practice. The next step is to compare that data to peer group data on a local and national level. Over time, the hospitalist program will have collected enough performance data to identify significant trends, areas of improvement, and benchmarks. In the meantime, many hospitalist programs establish best-practice benchmarks from data gathered by organizations such as the Society of Hospital Medicine (SHM) and the Medical Group Management Association, or from independent repositories such as VHA, Solucient, and Premier.

In Chapter 3, we will take a detailed look at who should be charged with collecting performance data and how programs can collect that data.

Quality care and patient safety measures

When developing a performance scorecard, the first step the program must have is to determine what data to collect. For guidance on this issue, turn to national healthcare trends. For example, awareness has grown over the past several years about the significant effect medical errors have on patient morbidity and mortality. As a result, the healthcare community and the

general public have focused more attention on the importance of healthcare quality and patient safety improvements. An increased emphasis has also been placed on making hospital and physician performance transparent.

In the wake of this movement, a consortium of organizations, including CMS, the American Hospital Association, and The Joint Commission, has initiated a national quality monitoring system called the Hospital Quality Alliance.

Many other organizations have defined physician and/or hospital performance measures as they relate to patient quality and safety improvements. These organizations include the National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), Leapfrog, and the Agency for Healthcare Research and Quality.

Many hospitalist programs have incorporated the performance measures endorsed by these various quality organizations (NQF, IHI, Leapfrog, etc.) and/or monitored by regulatory agencies (e.g. The Joint Commission, state regulators, etc.) when developing scorecard metrics.

When determining the metrics to include on the scorecard, pay special attention to metrics that measure return on investment for the subsidizing entity and those that evaluate the program's objectives. Metrics that evaluate areas in need of improvement and those representing patients' interests should also be incorporated into the scorecard.

Keep in mind that the addition or deletion of metrics is a dynamic process. Hospitalist programs should reevaluate their metrics periodically to reflect regulatory changes, new payer initiatives (e.g., CMS as seen with pay-for-performance measures), and program goals.

Finally, encourage hospitalists' input in developing new performance measures to include on the scorecard. Doing so will empower these providers to take ownership of both the program and the hospital systems, which will positively affect clinical outcomes and provider performance.

For additional information about performance scorecards, turn to *Measuring Physician Competency: How to Collect, Assess, and Provide Performance Data*, and *Hospitalist Case Studies: Tactics and Strategies for 10 Common Hurdles*, both published by HCPro, Inc.

Data analysis

Analysis of the performance scorecard will provide the hospitalist program with information about clinical and financial performance, including:

- Clinical guideline adherence
- Morbidity and mortality rates
- Clinical outcomes
- Resource utilization
- Productivity and efficiency
- Coding and documentation

The data may also have implications for hospitalist program structure (e.g., staffing numbers and the practice staffing model) and hospitalist practice policy (e.g., communication protocols and systems, hours of service, scope of deliverable services, etc.). Finally, analysis of the performance scorecard may provide information necessary to address hospitalist practice procedures. For example, data may support the need for:

- Interdisciplinary rounds
- Improvement in discharge planning
- Improvement to the hospitalist checkout process
- Medication reconciliation

Analysis of the data will also highlight the successes and failures of the hospitalist program and information systems in regard to their ability to collect the required data and to ensure that the data is accessible, accurate, reproducible, and timely. Data analysis may also uncover additional issues within the hospital, such as:

- Departmental staffing problems
- Procedural problems that contribute to patient throughput issues or discharge delays

- Clinical sinkholes
- Communication system failures
- Medical records deficiencies
- Patient safety concerns
- Ineffective transitions of care

The hospitalist performance team and committee

Hospitalist programs develop a performance scorecard with the overall goal of:

- Monitoring hospitalist provider and practice performance
- Documenting hospital performance
- Providing root cause analysis
- Identifying specific areas in need of improvement

To ensure that it attains these goals, the hospitalist program should create a hospitalist performance team and committee to support these initiatives. The performance team should include the:

- Hospital quality assurance and/or performance improvement (PI) director
- Vice president of medical affairs (VPMA)/chief medical officer (CMO)
- Chief financial officer
- Hospital administrator providing hospitalist program oversight
- Hospitalist clinical director
- Hospitalist practice manager

The performance committee may also include a representative from various departments on an as-needed basis. These guests may include the physician chief of service from the emergency,

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cardiology, pulmonology, surgery, pathology, radiology, internal medicine, family medicine, or pediatric department. Guests may also include directors from various hospital departments, such as:

- Information systems
- Nursing
- Social services
- Case management
- Utilization review
- Physical therapy
- Occupational therapy
- Pharmacy
- Laboratory
- Radiology
- Cardiopulmonary
- Surgery
- ED

The committee's first task is to identify sources of clinical and financial data. The second task is to develop systems to consolidate this information, which will improve both the hospital's and the hospitalist program's ability to generate specific reports (e.g., for a specific metric) and create a composite picture.

The committee's third primary task is to apply the data to make recommendations regarding hospital and hospitalist practice policies, procedures, and protocols.

Acting on scorecard data

Scorecards cannot live in a vacuum. After collecting the data, the hospitalist program must thoroughly analyze the scorecard data, track trends, and develop a summary report following each monthly, quarterly, and annual review of the data. This summary report must be standardized and include peer group comparisons. The comparisons may be blinded or nonblinded depending on practice culture.

Nonblinded performance data can create healthy competition among providers. Providers don't want to be identified as outliers, nor do they want to be responsible for bringing the team performance down. Openly sharing performance data may push providers to walk the extra mile, which will benefit that provider, his or her patients, the hospitalist practice, and the hospital with which the program has partnered. The hospitalist practice may opt to take the performance results to a higher level by creating an incentive program and rewarding the best performers.

When scorecard data exposes deficiencies within the hospitalist practice, it is ultimately the responsibility of the hospitalist clinical director to use this data to encourage provider behavioral change. The clinical director can bring about such necessary changes by educating all hospitalists in the program about the findings. He or she may involve the quality assurance and/or PI director as well as the VPMA/CMO in this process.

The clinical director should also create a written corrective action plan detailing the substandard performance and improvement recommendations (personalized for each provider). The report should include a follow-up plan with timeline for reevaluation. To ensure an effective and productive review process, the hospitalist who is subject to the plan should be given an opportunity to provide input.

The hospitalist clinical director may present the findings to the hospitalist performance committee (blinded) for educational purposes and for input from a systems perspective. This is critical when a hospital system or department is identified as an involved party—either contributing to or as a casualty of the deficiency.

When there are deficiencies within the hospital, the administration is responsible for providing the necessary tools to effect the desired change. The hospital must develop systems and

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processes supporting appropriate resource utilization by the hospitalists (e.g., provide informational systems [and/or staff support]) so that the hospitalist can make appropriate/cost-effective choices when:

- Ordering a diagnostic study (e.g., perhaps a guide for radiological studies with listed indications and costs for each study)
- Ordering a medication (e.g., a computer program that lists what's on the hospital formulary, the cost differences, indications, efficacy, drug–drug interactions, etc.)
- When planning outpatient discharge services (e.g., providing dedicated case managers for the hospitalist team, providing a list of outpatient social services available to the patient depending on his or her insurance, etc.)

The hospital must also develop systems to accurately measure the utilization and provide feedback to the providers.

Finally, the hospital board and administration should support hospitalwide implementation of new systems and processes that positively impact the clinical and financial performance of the hospitalist practice and the hospital as a whole. This must be accompanied by education of the hospitalist providers, medical staff, and hospital employees. For example:

- Hospitalists can educate administration about the dynamics of the provider team and the importance of synergy among team members from a clinical perspective
- Hospitalists must illustrate that an investment in these systems and processes will provide a positive return on investment for the hospital as evidenced by:
 - Improved quality of care and clinical outcomes
 - Decreased morbidity and mortality
 - Decreased unexpected readmission rates
 - Improved patient safety
 - Improved resource utilization

The expected outcome

The goal of the hospitalist performance scorecard and committee is to provide reliable data and feedback regarding hospitalist and hospital clinical and financial performance to identify areas in need of improvement and ensure the efficiency of the program. By collecting, analyzing, and sharing performance data, the hospitalist program will have the information it needs to improve patient care, ensure successful clinical outcomes, and improve the program's financial standing.

The data can also lead to improvements to hospital processes and systems, which will positively affect patient safety and the quality of medical care. It will also lead to an improved financial position and bottom line for the hospital.

A comprehensive and effective scorecard is the result of healthcare systems' commitment to partners to improve the quality and efficiency of medical care. By collaborating on such an important project, hospitalist programs and hospitals are adhering to Helen Keller's observation, "Alone we can do so little, together we can do so much."

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