

The Hospitalist Imperative: Standardizing Best Practice across Expanding Healthcare Networks

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Rapid dissemination and adoption of evidence-based guidelines remains a challenge despite studies showing that key evidence-based care processes improve outcomes in sepsis and heart failure.¹ Hospital medicine was virtually founded on the premise that hospitalists would be champions of delivering high-quality care. Hospitalists are now dealing with a new challenge—unprecedented growth of healthcare systems because of mergers and acquisitions. The year 2018 was a banner time for healthcare mergers and acquisitions, with a total of 1,182, up 14% from 2017.² These are in response to the belief that healthcare systems may better navigate the mixed reimbursement models of fee-for-service and fee-for-value by achieving a larger patient base and economies of scale. Hospitalists must now achieve consistent, evidence-based standards of care across larger networks by educating their colleagues (often separated by large geographic areas) to manifest durable changes in their group practice with demonstrable improvement in patient outcomes and cost savings.

The study by Yurso et al. focused on implementing an education program, which included standardized learning through Clinical Performance and Value (CPV) vignettes with process measurement and feedback for sepsis and heart failure.³ Sepsis and heart failure have been a focus for treatment standardization because of the associated morbidity, mortality, and high cost of care. The study by Yurso et al. is a prospective quasi-controlled cohort of hospitalists in eight hospitals who were matched with comparator hospitalists in six nonparticipating hospitals across the AdventHealth system. Measurement and feedback were provided using CPV vignettes. Over two years, hospitalists who participated improved CPV scores by 8%, compliance with the utilization of the three-hour sepsis bundle from 46.0% to 57.5%, and orders of essential medical treatment elements for heart failure from 58.2% to 72.1%. In year one, the average length of stay (LOS) observed/expected (O/E) rates dropped by 8% for participating hospitalists compared with 2.5% in the comparator group. By year two, cost O/E rates improved slightly resulting in cost savings. The authors concluded that CPV case simulation-based measurement and feedback helped drive improvements in evidence-based

care, which was associated with lower costs and shorter LOS.

While studies using traditional didactic CME struggle to demonstrate changes in practice leading to improved patient outcomes,⁴ the study by Yurso et al. gives a glimpse into how simulation can be used to help improve clinical performance and measure adherence to best practice. A remarkably similar study used CPV for simulated patients with serial performance measurement and feedback for heart failure and pneumonia. The study showed reduced practice variation between hospitalists at 11 hospitals across four states and decreased LOS and readmissions. However, the sole clinical outcome was no change in in-house mortality.⁵ Another study using CPV training in breast cancer treatment demonstrated increased adherence to evidence-based practice standards and decreased variation in care between providers across four states.⁶ Of note, this study did not include clinical outcomes. These studies collectively imply that simulation training with interactive learning, educational feedback, repetitive practice, and curriculum integration has shown modest success in creating practice change and improving adherence to best practice standards. However, they have minimal measures of patient outcomes and fairly simple analyses for cost savings. Because the education is computer-based and feedback can be performed remotely, it can be deployed across large and diverse growing healthcare systems. To really move the needle, future research in the field of simulation should identify optimal simulation methods and be designed with more rigor to include patient and cost outcomes.

At Intermountain Healthcare, hospitalist expansion occurred through a strategic realignment from the different geographic regions into the One Intermountain model. This model is built on the commitment that our patients will receive the same high-quality, high-value care wherever they walk through our doors. We have found four substantive changes have been particularly powerful in spurring a group practice mentality toward standardizing best practice. One, hospitalists are now aligned across the system under a single operational leadership structure that encourages combined efforts to share best practices and develop and deploy strategic initiatives around them. Two, hospitalists continue to build on a culture of quality and measure what matters to patients. While Intermountain Healthcare has a long history of using quality improvement to achieve better patient outcomes and lower costs,⁷ the new structure is allowing our group to test novel methods including redesigned education to see what actually improves adherence to

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Received: May 30, 2019; Accepted: June 1, 2019

© 2019 Society of Hospital Medicine DOI 10.12788/jhm.3257

best practice. Three, the group knows where the system's reimbursement is coming from; Intermountain Healthcare has transitioned to a larger percentage of capitation,⁸ currently about 40%, with a strong commitment to partner with services geared to transition patients home quickly and keep them at home. Four, the organization has created a structure of accountability and reporting; an executive-sponsored systemwide operating model has been designed to cut through system barriers being identified by the frontline, allowing them to be rapidly surfaced and then solved at the executive level through daily huddles.⁹

Innovative educational programs such as the one described in the study by Yurso et al. that help the busy hospitalist achieve improved adherence to best practice are likely to be an important component leading to improved outcomes, but only after a group has been structured for success. As hospitalist groups continue to act as a single effector arm for high-value care, this will help meet the expectations of our patients and deliver on the promise of our field.

Disclosures: Dr. Srivastava is a physician founder of the I-PASS Patient Safety Institute. His employer, Intermountain Healthcare owns his equity in the I-PASS Patient Safety Institute. Dr. Srivastava is supported in part by the Children's Hospital Association for his work as an executive council member of the Pediatric Research in Inpatient Settings (PRIS) network. Dr. Srivastava has received monetary awards, honorariums, and travel reimbursement from multiple academic and professional organizations for talks about pediatric hospitalist research networks and quality of care. All other authors have nothing to disclose. No funding was provided for this editorial.

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