Health Policy Newsletter

Volume 18 Number 1 **March, 2005** **Article 6**

Hospital Medical Services Entering Ninth Year at Main Line Health

Charles E. Meidt, MD*

* Main Line Health

Suggested Citation:
Meidt CE. Hospital medical services entering ninth year at Main Line Health. Health Policy Newsletter 2005; 18(1): Article 6. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol18/iss1/6.

Hospital Medical Services Entering Ninth Year at Main Line Health

The use of hospitalists, dedicated inpatient physicians, has long been the model for hospital care in the Canadian and many European healthcare systems. This practice was not adopted in the United States until the late 1990's, and even then hospitals, and particularly primary care providers, were slow in accepting this new model of care delivery. As the uptake of the model increased, due to increasing financial, clinical and time pressures, hospitalists evolved from the defined "physicians who spend at least 25 percent of their professional time serving as the physicians-of-record for inpatients" to being fully-dedicated inpatient care providers.1,2 At the early stages of this movement, Main Line Health was part of an innovative group of facilities who recognized the potential benefits to both patients and the hospital. Its story illustrates the challenges and achievements faced by many who strive to implement this often disputed model.

Hospital Medical Services (HMS), the hospitalist program at Main Line Health began assuming the care of inpatients at Bryn Mawr Hospital in December of 1996 with subsequent expansion to Paoli Hospital in 2000. An independent hospitalist group associated with the internal medicine residency at Lankenau Hospital soon followed. Though common in other areas of the country, ours was one of the first pure hospitalist groups to be up-and-running in the Delaware Valley. The program quickly proved valuable to patient care from the perspective of both quality and efficiency. Secondary to this, and to the support of both primary care and subspecialty physicians, we have grown exponentially over the past eight years. This change in the healthcare paradigm has proved rewarding and, at times, challenging.

Initial hurdles encountered during the evolution of HMS included concern that patients would be dissatisfied with trading their primary care physicians (PCP's) for an unknown physician during hospitalization. PCP's worried that some patients may be lost from their practices in follow-up to this new medical group. HMS overcame these concerns by designing a practice focused solely on inpatient care. Patients for the most part were willing to trade familiarity with their own doctors for the 24-hour, in-hospital availability and expertise of the H.M.S. group. This agreement, of course, required that PCP's were supportive and remained informed of the hospital course of their patients. This need for improved communication led to substantial changes in the mission and role of health information managers charged with keeping outpatient physicians informed about inpatient care.

Another challenge faced by most hospitalist groups initiating this new mode of practice involves educating other healthcare team members about the hospitalist role. Others have a hard time acknowledging that hospitalists are indeed the attending physicians of record with primary responsibility for directing the course of inpatient care. We are not residents, house staff, or house physicians. All the hospitalists in the group are board certified medical physicians who specialize in the care of patients who are unfortunately sick enough to be hospitalized. In the present healthcare environment, patients deemed sick enough for hospitalization are in fact so ill that there is a definite advantage to having ever-present physicians assigned to their care. A corollary to this is that patients who were once thought sick enough to require hospitalization are now being cared for on an outpatient basis and require the focused care of skilled outpatient physicians. The number of calls generated by

inpatients these days can be burdensome and distracting to PCPs' outpatient care. The division of labor between inpatient and outpatient care is a solution to this challenge.

After first, this substantial change to the status quo felt disruptive. Yet, once the hospitalist program gained momentum, most saw this new arrangement as simply and demonstrably making more sense than the prior model of providing inpatient care. Data from Bryn Mawr Hospital illustrates the fact that the hospitalist model not only is gaining acceptance but also is improving care. During 2004, HMS physicians cared for 3,089 patients, 50 percent more than the number of patients seen by Internal Medicine physicians. As a result of their skilled decision-making and hospital care knowledge, length of stay for HMS patients averaged 3.9 days, compared to the average 5.3 for patients being cared for by the non-hospitalist. With this major hurdle of acceptance overcome, hospitalists in the HMS program are facing new challenges – keeping pace with the rate of growth of the program.

With demonstrated managerial, policy, and clinical advantages, the hospitalist model is proving to be an efficient way of delivery high quality inpatient care.3 HMS is one example of the power and progress of the hospitalist movement, now over 7,000 physicians strong.4 HMS now admits the majority of medical cases to both Bryn Mawr and Paoli Hospitals. Our hospitalists routinely see between 100 and 140 patients daily and provide behind-the-scenes services without which these hospitals now could not function. We have come a long way since our first morning sign-in eight years ago when we sat in our office staring at each other wondering when we would get our first patient.

References

1. "Introduction to the Hospitalist Model", The Emerging Role of Hospitalists in American Health Care: A National Conference, December 5-6, 1997, San Francisco, California, presented by Department of Medicine, University of California, San Francisco School of Medicine Robert M. Wachter

2. Baudendistel TE, Wachter RM. The evolution of the hospitalist movement in the USA. *Clin Med*. 2002;2(4):327-30.

3. Harrison JP, Ogniewski RJ. The hospitalist model: a strategy for success in US hospitals? *Health Care Manag* (Frederick). 2004;23(4):310-7.

4. Freed DH. Hospitalists: Evolution, evidence, and eventualities. *Health Care Manag* (Frederick). 2004;23(3):238-56.

About the Author

Charles E. Meidt, MD, is Medical Director for Hospital Medical Services at Main Line Health.