Health care imperative for practice model change

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Am J Health-Syst Pharm. 2011; 68:1096-7

We are living in a time when the hospitals in which we work are changing right under our feet. The patients we now see are more acutely ill than patients seen just 10 years ago, and when they arrive at the hospital for care, we must move them through the system quickly, as the beds on the medical floors and intensive care units are in high demand and the emergency department is overcrowded.

This is a summary of a speech at the Summit. An audio recording of the full speech, synchronized with slides, may be accessed at www.ashp.org/ppmi/watch-wellikson.

This need for better coordination of care comes at a time of significant challenges to the executive leadership of hospitals. Some institutions are fighting for their fiscal survival because of the media attention given to medical errors. Turnover in nursing and other health professional staffs is substantial. There has been a marked realignment of many physicians’ hospitals of choice, which has put some hospital’s future in jeopardy.

While hospitals are trying to provide round-the-clock medical services, many physicians (e.g., primary care doctors, neurologists) are leaving their hospital affiliations, and surgeons, subspecialists, and orthopedists are narrowing the scope of their practices. Some physicians are establishing their own procedure or surgical centers in direct competition with local hospitals.

Population demographics are having a major effect on hospital care. The fastest growing age patient population comprises individuals over age 100 years, and the Baby Boomers are just cresting their senior years. While per capita health expenditures in the United States are more than double that of the median health care costs for developed countries, we often misallocate these dollars, and the measurable outcomes our patients achieve are well below those of many other developed countries.

Recent national health insurance reform has set the stage for increased access to care with perhaps dubious promises of cost reductions and improved performance. There will be experiments with accountable care.
care organizations, bundling of care, and value-based purchasing and an attempt to move away from fee-for-service payments.

Reinventing acute care. The only way out of this conundrum is to reinvent acute care. There must be a new “home team” in the hospital that includes the hospitalist, the emergency care physician, and the intensivist partnered with nurses, pharmacists, case managers, social workers, and therapists. Members of this team will see the hospital as their primary workplace and will palpably see the need to transform the dysfunctionality of hospital systems of care.

The hospital of the future will need to be patient centered, defined by measurable quality, and delivered by teams of health care professionals. Measurement of success will need to be at the level of the team, not of the individual.

Teamwork. There will need to be a shift in hierarchy to allow all team members to be empowered to deliver best practices. Health care protocols, designed by the team, must be in place. A system for continuous quality improvement will need to be in place so that everyone can learn from past experiences. We will need to leave our silos and talk to each other.

There must be team education to ensure that all members know the same things, which is all the more difficult because we received our initial education separately. Real-time communication across shifts and professional disciplines is a prerequisite of best care. This involves much more than just an electronic medical record and may require multidisciplinary rounds and a culture that is open to criticism and transparency.

We will need to overcome the geographic barriers within health systems and figure out how to integrate the many health care professionals who might be called on to care for each individual patient.

Conclusion. The status quo is not a tolerable solution, and many forces within and outside of health care are driving this imperative for change. It is time now for leaders in medicine, pharmacy, nursing, and elsewhere to set the direction for the hospital of the future.

Changing the pharmacy practice model: A health-system executive’s view

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Am J Health-Syst Pharm. 2011; 68:1097-8

Today’s health-system executives are faced with many challenges, including ensuring quality improvement and public reporting of quality measures, dealing with declining revenue and stagnation in the general economy, managing the growing numbers of uninsured and underinsured patients, finding opportunities to create new services and to serve new markets, investing in information technology, and ensuring employee and population wellness.

Succeeding under health insurance reform. To succeed under national health insurance reform, hospitals must have the following four core competencies:

1. Sophisticated information technology systems. These systems enhance efficiencies, streamline services, and improve quality and include electronic health records that provide real-time outcome measures and foster continuity of care between inpatient and outpatient settings.

2. Physician integration. Strategic options for physician integration include independent medical staff membership, an administrative services contract, a clinical services contract, joint venture arrangements, and full-time employment. Additional new compensation models to attract and retain physicians should also be adopted.

3. Effective and efficient management of patient care quality and the continuum of care.

4. Pricing transparency. Hospitals must publicly report charges for diagnosis-related groups and ensure that pricing methodologies adequately address future changes in reimbursement.

Transition to the future. Hospitals’ transition to the future will be very challenging. One of the top priorities will be to find sufficient