

A Unit-Based Approach

Practicality favors putting most hospitalist patients in one place



Would you want all your patients on the same nursing unit? Think about it—no more walking all over the building to see a few patients on each floor.

Because you would be physically present on “your” unit nearly all day, you could develop close working relationships with the nurses and other caregivers, which might improve everyone’s satisfaction with work. Everyone could better anticipate your work flow and communicate this to patients and families. You likely would be paged much less often because the nursing staff could keep track of whether you’re with a patient or off the floor to attend a conference; they could hold non-urgent issues until you get back.

All these things might make you and others more efficient—able to see the same number of patients you see today in less time, while maintaining or improving quality and cost effectiveness.

Sound familiar? The idea that working at only one site leads to efficiency and quality improvement is one of the underpinnings of the hospitalist concept. Instead of covering the outpatient office and hos-

pital every day, doctors can focus on only the hospital or only the office. But what if you extended that idea to focusing your practice on only one unit within the hospital rather than the whole building? Would that be a good idea and lead to the benefits described above, or would that be taking the idea of “focused practice” too far?

Before answering, I should describe the approaches some practices have taken to pursue the benefits of concentrating patients in one part of the hospital. I’ll refer to this idea as “unit-based hospitalists,” the term current SHM President Rusty Holman uses when talking about this idea.

Locate most hospitalist patients in one unit. This is the most common form of unit-based hospitalists. Most institutions find the closest they can get to unit-based hospitalists is to have all hospitalist admissions go to the same floor when that floor has a bed available and the patient doesn’t require placement elsewhere. In such cases, the hospitalist practice might have something like 50% of patients on that floor and 50% dispersed throughout the hospital (telemetry, ICU,

surgery floor). So the whole hospitalist practice has a primary “home” within the hospital, while each hospitalist spends part of each day caring for patients elsewhere. This is not very difficult for most hospitals to implement—and many are because most hospitalist patients end up on the “general medical” floor. This lets the hospitalist spend more time on that unit than any other. She can get to know the staff on that floor better, which might lead to many benefits, including improved satisfaction and efficiency.

Locate individual hospitalists on different hospital units. A more pure, but uncommon, form of unit-based hospitalists involves changing the way hospitalists are placed through the institution rather than changing patient placement. Each hospitalist in the group is assigned to a different nursing unit—or perhaps more than one unit—and sees whichever hospitalist patients are placed there. This system has the advantage of the hospitalist working all or most of the day on the same nursing unit, which can foster excellent teamwork. Instead of the nurse having to

figure out which hospitalist to page for a particular patient, he simply needs to know, “Who is our hospitalist today?” and can contact that doctor for issues on most patients. Additionally, because the hospitalist will spend nearly the whole day physically on that unit, paging can be reduced significantly.

Despite its advantages, basing an individual hospitalist on a particular unit of the hospital is uncommon because in its purest form it can lead to terrible hospitalist-patient continuity. And, it’s hard to be confident that the disruptions in continuity are worth the benefits of the unit-based system. For example, the practice may have a patient to admit in the ED but can’t know which hospitalist should see the patient until a room is assigned. The fifth-floor hospitalist might go admit the patient in the ED, only to have the patient end up on the third floor, in which case the third-floor hospitalist would take over the next day. And each time the patient transferred to a new unit, either because of medical needs such as telemetry or simply because the hospital is full and needs to move patients, he would get a new hospitalist.

In addition to problems with continuity for patients who occupy more than one unit during their stay, this system would mean individual hospitalist workloads might get far out of balance. One floor might be very busy, while another is slow or limited by nurse staff shortages, and the respective hospitalists would have a correspondingly out-of-balance work-

load. A group could decide to address these problems by, for example, having the fifth-floor hospitalist see patients in other parts of the hospital in an effort to provide better hospitalist-patient continuity and address out-of-balance patient loads. But if this happens with any regularity it would mean the group has essentially moved back to a non-unit-based system.

In nearly all hospitals it would be unnecessary and unreasonable to assign a hospitalist to each nursing unit because some units tend to have few hospitalist patients. Yet when patients end up in those units because of medical necessity or bed space needs, one of the hospitalists will have to leave his/her unit to see this patient. If this happens often enough, it begins to dilute or negate the benefit of basing a hospitalist in one or two units.

Although one of the potential benefits of the unit-based model is enhanced relationships and integration among hospitalists and other unit-based clinical staff, it would be difficult to ensure that the same one or two hospitalists always work in a particular unit, and would limit scheduling flexibility dramatically. For example, if Dr. Starsky and Dr. Hutch are the unit-based hospitalists for Unit A, what happens if Dr. Starsky and Dr. Hutch are both scheduled to be off for the same block of days? What happens if both are scheduled to work the same block of days? To obtain the benefits of enhanced relationships and better unit integration, the practice would need to ensure that this scheduling overlap rarely happens—and that’s hard to do.

Where is the sweet spot in grouping patients and hospitalists by nursing unit? There is a wide range of opinion about whether unit-based hospital medicine in any form is worth pursuing. Some hospitalists are convinced that grouping all of their patients on the same unit could decrease efficiency because the doctor is nearly always working within view of patients and families and may be regularly interrupted. I am convinced that assigning each hospitalist to a particular unit in the hospital yields the greatest benefits. But I also think most institutions will find that the complexity and costs of this system are simply too high to justify. In that case, the next best approach might be to locate most hospitalist patients on the same unit unless that unit is full or the patient must be placed elsewhere. There is a good chance this is happening in your hospital—even if it isn’t written in the policy manual. **TH**

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