

Affirming the Firm System- NYU Hospitals Center Pilot

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Context: A Climate of Change

- Difficulty in communication between Attending and Housestaff (Capstone Project 2007).
- Difficulty in complying with Residency Review Committee rules that residents must relate to no more than eight physicians.
- Need to enhance teaching of the six ACGME competencies, especially professionalism, interpersonal communication skills and systems-based practice knowledge.
- Need to comply with Patient Safety Initiatives calling for a reduction in Hand-offs.
- Problems communicating *within* a large residency program (162 housestaff, including preliminary interns).
- Variation in admitting volume amid a large voluntary faculty dispersed into two large and many small offices.
- Untapped resources amid the growing hospitalist program.
- Dissatisfaction amongst Nurse Practitioners regarding discontinuity and ineffective communication when patients are transferred between the teaching and nonteaching services.
- Lack of geographically-centralized teams hampers Interdisciplinary Care efforts.

Core beliefs: Less is More

- Effective communication and interpersonal satisfaction is enhanced by an organizational structure that promotes individual relationships developing over time.
- Interpersonal relationships enhance communication leading both to better patient care and more effective teaching.
- “Bad apples” are dealt with more efficiently in a smaller community; exceptional individuals come to light more easily.
- Continuity between sites of care - including the office, the wards, the step down and the ICU - is an important goal in organizing hospital services.

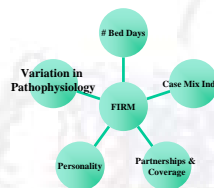
Methods: Redesigning the Medicine Service

- Assignment of Major Admitters to four general medicine firms. Major Admitters are those responsible for 80% of 2006 bed-days in Medicine.
- Hospitalist appointed as firm leader Geographic distribution of patients as much as possible.
- Admission of patients with primarily cardiological problems to a cardiology firm with enhanced housestaff coverage.
- Creation of geriatric and hematology/oncology firms with their own housestaff teams.
- Establishment of an interdisciplinary team consisting of firm leader, resident, intern, nurse practitioner, care manager, pharmacist that makes daily rounds.

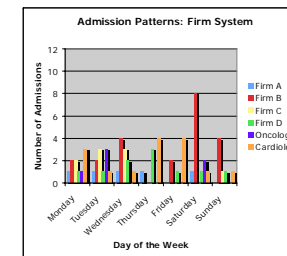
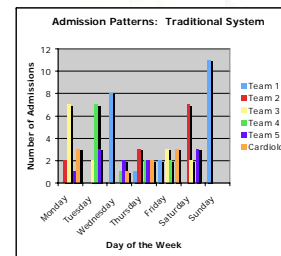
Barriers to Implementation: Multiple and Formidable

- Attendings
 - What to do with subspecialty consults?
 - Alliances between attendings/groups at odds with criteria for division
 - Concern about being stuck with “bad” housestaff
 - Concern about youth of the hospitalists
 - Will hospitalists come to dominate care of private patients?
- Institution
 - Adequacy of evening coverage in light of late-ED peaking admissions from ED
 - Physical plant (limited, ongoing construction)
 - Salaries for additional NPs
 - IT Support
- Nursing
 - Geography (patient identification with firm takes precedent over nursing/patient relationship leading to frequent transfers)
 - Step down units not affected by firms
- Nurse Practitioners
 - Uneven and variable patient loads
- House staff
 - Admitting every day
 - Uneven and variable patient loads
 - Weekend schedule
 - Concern about being stuck with “bad” attendings.
 - Skepticism about the systems’ ability to decrease the number of physicians with whom they must communicate
 - Holding patient in the ED awaiting correct geography
 - Assignment of patients to the cardiology firm by the chief resident
- Admitting
 - Ability to create meaningfully geographic division of patients
- Care Management
 - Use of early morning for interdisciplinary vs. work rounds
 - Ability to cover two firms on a floor

Factors Determining Allocation of Attendings into Four Firms



The Admitting Cycle: Moving From “Feast or Famine” to the “Continuous Infusion”



Intended Outcomes: Win-Win for All

- Enhanced satisfaction for the entire healthcare team: attendings, housestaff, nurse practitioners, nurses, care managers, nurse managers, medical students, pharmacists.
- Meaningful mentoring relationships develop between a largely untapped voluntary faculty and the housestaff.
- Improved patient care (reduced hand-off communications, reduced length of stay, discharge summaries given to patient at time of discharge).
- Closer involvement of the Nurse Practitioners in the Medicine Service (CME, supervision, daily consultation, and smooth transitions between teaching and nonteaching within context of the firm).
- Enhanced communication across groups of primary care doctors
- Continuity with a residency-wide firm system
- Increased communication between private faculty and hospitalists
- Decreased length of stay
- Reduced ancillary costs through duplicative testing
- Institution-wide roll out of firm systems using this process as a model