Background: Inpatient healthcare in the United States is undergoing rapid change in the face of federally mandated reform the Affordable Care Act. New payment structures and financial incentives have put an increased focus on health care quality and patient outcomes. As an example, the CMS Bundled Care Payment Initiative will provide one payment to cover all physicians, facility, and rehabilitation costs for a total joint replacement episode of care. These changes are aimed at incentivizing better inpatient care coordination. Interdisciplinary rounds have been show to improve multiple quality metrics in drivers clinical settings. Hospitalists are in a position to lead multidisciplinary round in an effort to meet the aforementioned objectives due to their co-management and consultation relationships with surgical service lines.

Purpose: We hypothesized that implementation of interdisciplinary rounds on our THA/TKA service would 1) increase the percentage of before 2pm discharges by 20% and 2) decrease overall LOS 5% for all total knee and total joint patients by enhancing communication and care coordination among all involved disciplines.

Description: The University of Colorado Orthopedic Service line geographically cohorts all total knee and total hip replacement patients on a single floor of a 593-bed quaternary medical center. The patient population is socioeconomically diverse and medically complex. The service completes approximately 200 total joint replacements monthly. The service stakeholders include the orthopedic surgery team, hospitalist co-management team, registered nurses, pharmacist, physical and occupational therapists, case manager, social workers, and nutritionist. Our project team consisted of 4 hospitalist residents, a nurse manager champion, and process improvement specialist. We created an interdisciplinary rounds script that included both speaking order and talking points. Its rollout was our first PDSA cycle from 6/22/15 to 7/27/15. Data was collected via hospital EMR. Baseline for the prior 6 months were 3.2 and 3.6 days LOS for THA and TKA respectively, with 45% of patients discharged before 2pm. After PDSA cycle 1, discharges prior to 2pm increased to 51% with LOS reduced to 3.1 days in our TKA population while THA increased to 4 days. Data for our primary balancing measure, 30-day all-cause mortality is pending further PDSA cycles. Barriers to initial implementation included non-adherence to rounding script, inconsistent attendance to rounds, and concern for increased workload from multiple providers.

Conclusions: Development of interdisciplinary rounds was straightforward, but implementation has been more difficult. Our program is still in its infancy and has not demonstrated a meaningful effect on clinical outcomes. Future interventions to consider will include refining the rounding script, improving collection of data surrounding delays in discharge, implementing an EMR dashboard, and incorporation the prior day's performance into rounds.