Hospitalists: What You Need to Know

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Agenda

1. Current State of Hospital Medicine
2. Hospitalist Stakeholders and Managing Priorities
3. What value are Hospitalists looking to achieve?
4. Leading Practices for Hospitalist Teams
5. Looking Forward

Learning Objectives

✓ Understand the processes by which more information may be passed between physicians resulting in better patient care?
✓ Recognize situations where communication may be imperfect?
Poll Everywhere Instructions
Question 1: Where in Missouri are you from?

- Test Poll Everywhere Access
Current State of Hospital Medicine
Definitions

• Introduced in 1996, described by Bob Wachter and Lee Goldman in the NEJM piece
  • Specialists in Internal Medicine – who will be responsible for managing the care of hospitalized patients in the same way that primary care physicians are responsible for managing the care of outpatients

• Now and per Society of Hospital Medicine (SHM)
  • Physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to hospital medicine
Question 2: Do you work with Hospitalists now?

a) Yes, I work closely with Hospitalists
b) Yes, I work with Hospitalists on occasion
c) No or I rarely work with Hospitalists
Our growth in the last 2 decades

Data from the American Hospital Association which began tracking in 2003
Missouri Numbers

- Population: 6,135,888
- Total MO physicians: 19,286
  - Other: 10,294
  - PCPs: 8,992
- Number of Hospitals: 170
- University Hospitalists estimates
  - MU: ~11-12
  - SLU: ~15
  - WashU: ~70-80
Composition of Hospitalists

Which Specialists Are Hospitalists?

- Internal Medicine 39%
- Pediatrics 13%
- Psychiatry 10%
- Family Medicine 7%
- Anesthesiology 5%
- Ob/Gyn 4%
- Neurology 3%
- Critical Care 3%
- Radiology 2%
- Pathology 2%
- Emergency Medicine 2%
- General Surgery 2%

Medscape Hospitalist Compensation Report 2017
What else has changed?

American Hospital Association
https://www.aha.org/system/files/content/00-10/100715-CMItrends.pdf
Patients are sicker

Table. Inpatient hospital death rates, by first-listed diagnosis: United States, 2000, 2005, and 2010

<table>
<thead>
<tr>
<th>First-listed diagnosis</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
<th>Percent change¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per 100 persons hospitalized for diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.5</td>
<td>2.2</td>
<td>2.0</td>
<td>-20</td>
</tr>
<tr>
<td>Respiratory failure</td>
<td>25.3</td>
<td>19.3</td>
<td>16.5</td>
<td>-35</td>
</tr>
<tr>
<td>Pneumonitis due to solids and liquids</td>
<td>17.4</td>
<td>15.2</td>
<td>13.6</td>
<td>-22</td>
</tr>
<tr>
<td>Septicemia</td>
<td>13.9</td>
<td>19.3</td>
<td>16.3</td>
<td>+17</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>9.9</td>
<td>6.5</td>
<td>3.5</td>
<td>-65</td>
</tr>
<tr>
<td>Cancer</td>
<td>8.1</td>
<td>6.8</td>
<td>4.4</td>
<td>-46</td>
</tr>
<tr>
<td>Stroke</td>
<td>6.4</td>
<td>6.5</td>
<td>4.7</td>
<td>-27</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>4.9</td>
<td>3.3</td>
<td>3.3</td>
<td>-33</td>
</tr>
<tr>
<td>Heart disease</td>
<td>3.7</td>
<td>2.8</td>
<td>3.1</td>
<td>-16</td>
</tr>
</tbody>
</table>

¹Percent change for total and each diagnosis is significant change from 2000 to 2010.

Centers for Disease Control and Prevention
https://www.cdc.gov/nchs/products/databriefs/db118.htm
Hospitalist Stakeholders and Managing Priorities
Hospitalist groups are coordinating priorities of multiple stakeholders.

- Managed Care Organizations:
  - LOS
  - Readmissions
  - Managed cost
  - Predictability
  - Communication
  - Physician Consistency
  - Results
  - Cost

- Hospitals:
  - Patient Safety
  - Profitability
  - 24/7 Support
  - Capacity
  - Coordination
  - Communication
  - Billings

- Hospitalists

- Physicians

- Patients
Managed Care Organization priorities and challenges

• Have contracts with healthcare providers and facilities which tightly control both the utilization of services and the amount charged for these services.

• Set guidelines for determining when given surgeries are needed, what tests are appropriate, how long a patient should remain in the hospital, and so on in goals of preventing unnecessary surgeries and needless tests.
Hospital priorities and challenges

• Held to many standards
  - JCAHO
  - AHRQ
  - UHC
  - Press Ganey

• Can lose money to MCOs
  - Slow or delayed payments.
  - Underpayments.
  - Bundling of charges.
  - Retrospective and concurrent payment denials.
  - Onerous documentation requirements that slow down payments.
  - Payment exclusions for treatments considered experimental even though they have been used for years.
  - Precertification and prior authorization for outpatient procedures that are later denied because benefits expired or patient information is incorrect.
  - Day carveouts, where MCOs refuse to pay for the last day of a patient's stay.
Physician priorities and challenges

- Hospitalists disrupt the continuity of care
- PCPs feel they are abandoning their patient
- PCPs think they are stealing their work
- Hospitalists can not provide the same quality of care as I do
- Hospitalists are ‘super’ residents
Patient priorities and challenges

- Efficient and timely care
- Lack of continuity
What value are Hospitalists looking to achieve?
Value of a Hospitalist: having onsite dedicated support creates efficiency

- Increased communication
  - Care team (nurses, SW, therapy etc)
  - Patients and their families
  - Consultants, other provider teams
- Quick follow-ups and turnaround times on test results
- Increased familiarity with hospital policies and activities
- Need for more specialized and coordinated care of the hospitalized patient
Having the onsite support then allows high value care

- Reduction in LOS
- Reductions in cost
- Improvement in patient safety/decreased medical complications
- Increased staff satisfaction
First proven in 1998

At Moffit-Long in CA, for 1 year July 1995-June 1996

- 800 patients, 2 groups with Hospitalists found to have:
  - DECREASED LOS by 0.6 days and cost by $700
  - No change noted in Readmission rates, Patient satisfaction or Mortality

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>1993-1994</th>
<th>1994-1995</th>
<th>Traditional Service</th>
<th>Managed Care Service</th>
<th>P Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unadjusted length of stay, mean (SD), d</td>
<td>5.3 (± 4.8)</td>
<td>5.0 (±4.8)</td>
<td>4.8 (± 4.3)</td>
<td>4.3 (± 3.5)</td>
<td>.04</td>
</tr>
<tr>
<td>Adjusted length of stay, d†</td>
<td>5.2</td>
<td>5.0</td>
<td>4.9</td>
<td>4.3</td>
<td>.01</td>
</tr>
<tr>
<td>Unadjusted hospital costs, mean (SD), $‡</td>
<td>8631 (± 9213)</td>
<td>8120 (± 9405)</td>
<td>7501 (± 7892)</td>
<td>6950 (± 7289)</td>
<td>.22</td>
</tr>
<tr>
<td>Adjusted hospital costs, $‡‡</td>
<td>8509</td>
<td>8078</td>
<td>7777</td>
<td>7007</td>
<td>.05</td>
</tr>
<tr>
<td>Patients with consultations, %</td>
<td>42.1</td>
<td>36.4</td>
<td>32.5</td>
<td>31.6</td>
<td>.69</td>
</tr>
<tr>
<td>No. of consultations per patient among patients with any consultations, mean (SD)</td>
<td>1.5 (± 0.9)</td>
<td>1.5 (± 0.9)</td>
<td>1.5 (± 1)</td>
<td>1.3 (± 0.7)</td>
<td>.06</td>
</tr>
</tbody>
</table>

Hospitalist decrease the LOS without increasing the cost

• 2012 Meta-Analysis of 17 studies, totaling over 137,000 patients

Table 2. Comparison Between Resident and Non-resident Services for LOS and Cost Between Hospitalists and NHs

<table>
<thead>
<tr>
<th>Comparison</th>
<th>LOS Difference (days)</th>
<th>Cost Difference ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-resident hospitalist</td>
<td>-0.69 (95% CI -0.93 to -0.46)</td>
<td>-73 (95% CI -516 to 369)</td>
</tr>
<tr>
<td>Non-resident NH</td>
<td>N = 102,684</td>
<td>N = 99,122</td>
</tr>
<tr>
<td>Resident hospitalist</td>
<td>-0.36 (95% CI -1.07 to 0.33)</td>
<td>+890 (95% CI 53-1729)</td>
</tr>
<tr>
<td>Resident NH</td>
<td>N = 16,836</td>
<td>N = 7,333</td>
</tr>
<tr>
<td>Non-resident hospitalist</td>
<td>+0.12 (95% CI -0.48 to 0.72)</td>
<td>-1222 (95% CI -3173 to 729)</td>
</tr>
<tr>
<td>Non-resident NH</td>
<td>N = 19,689</td>
<td>N = 11,266</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; LOS, length of stay; NH, non-hospitalist.

Leading Practices for Hospitalist Teams
Question 3: What is your specialty?

a) Primary Care
b) Hospitalist
c) Surgeon
d) Other
Leading Practice Topics

• Providing High Value Care
• Setting the Right Metrics
• Patient Management Structures
• Staffing Optimization
• Patient Care Team Management
• Co-Management
• Communication and Transitions of Care
Providing High Value Care

• If this patient was in the office, would they be sent to the hospital to be admitted?
• Choosing Wisely campaign
• Eliminate waste
• Patient specific care plans
Setting the right metrics: Types

- Quality
- Engagement
- Financial
Setting the right metrics: Quality

A few examples include:

- Medication reconciliation accuracy
- Readmissions
- Hospital-Acquired Infection (HAI) reduction
- Order set compliance
Setting the right metrics: Engagement

Consider the following measures:

• Provider satisfaction
• Ancillary services satisfaction
• Recruitment and retention (for both specialists and hospitalists)
• Patient satisfaction
Setting the right metrics: Financial

Here are a few examples of data points:

- Clinical documentation accuracy
- Length of stay
- Resource utilization
- Cost per case
Patient Management Structures: Patient Ownership

1. Primary Hospitalist with specialty consultation as needed
2. Primary Hospitalist with specialty co-management
3. Specialty primary with Hospitalist co-management
4. Specialist primary with Hospitalist consultation as needed
Staffing Optimization: Team Size

• How to find the sweet spot
  • Determine who is medically necessary to see
    • Hospital size may factor in to this
  • Evaluating benchmarks of RVUs with your current hospital culture
    • Min-max number admits/day/person
    • Safe levels of cross coverage
  • APPs

• Recruiting methods
Staffing Optimization: Scheduling

- Rotational Schedules
  - Consistent (7-on, 7-off)
  - Periodic (14-on, 7-off)
- Shifts

- Set Time vs. Patient Based
  - Common to have set start and/or end times
  - Configurations with swing shifts, nocturnist, and moonlighting
Patient Care Team Management: Who’s on the Team?

- Multi-disciplinary rounds
  - Hospitalist
  - Nurse
  - Case manager/social work
  - Pharmacy
  - Therapy

- Geographic rounds

- Meet more than once a day
Question #4: How frequently are you getting your quality metrics from the hospital?

a) Monthly 
b) Quarterly 
c) Yearly 
d) Never
Partnership between a hospitalist and specialist in which both understand their roles and responsibilities to the patient while both actively managing the patient.
Co-Management: Why use it?

• Decreased LOS
• Decreased cost
• Decreased 30 day readmission rate
• Decreased medical complications/improved patient safety
• Decreased mortality
• Preferred by providers/staff
Co-Management: Set clear expectations

Need:
• Clear agreements
• Conflict resolution plans
• Scopes of practice to be maintained

If not clearly defined, inconsistent expectations or frequent misinterpretation of roles may develop for key hospital personnel, such as nursing staff, other medical staff members and even the co-managers themselves.
Co-Management: Things to consider

• Provider engagement
• Current culture
• Training, knowledge base and experience of Hospitalists
• Impact of staffing and provider satisfaction
• Role of APPs
• Financial impact
Co-Management: Dividing the work

<table>
<thead>
<tr>
<th>Aspects of Patient Care</th>
<th>All Care</th>
<th>Standard Care</th>
<th>Comanagement Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care team</td>
<td>Composition of orthopedic surgery team Orthopedic surgery faculty and resident</td>
<td>Consultative medical specialty teams (faculty and resident)</td>
<td>Hospitalist faculty (no residents); consultative medical specialty teams (faculty and resident)</td>
</tr>
<tr>
<td>Composition of medical team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing personnel</td>
<td>Predominantly registered nurses on 1 of 2 specific orthopedic surgical floors</td>
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<tr>
<td>Direct patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadesthetic medical examination</td>
<td>General internist, medical subspecialist, or anesthesiologist</td>
<td>Hospitalist</td>
<td></td>
</tr>
<tr>
<td>Daily patient evaluation during hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perioperative medical care</td>
<td>Orthopedic surgical team</td>
<td>Hospitalist—Orthopedic surgical team</td>
<td></td>
</tr>
<tr>
<td>Subspecialty medical consultation</td>
<td>Discretion of orthopedic surgical team</td>
<td>Discretion of hospitalist</td>
<td></td>
</tr>
<tr>
<td>Responsible team to nurses’ postoperative patient care concerns</td>
<td>Orthopedic surgical team</td>
<td>Hospitalist (medical issues); orthopedic surgical team (surgical issues)</td>
<td></td>
</tr>
<tr>
<td>Discharge responsibilities</td>
<td>Surgeons contact referring physician</td>
<td>Hospitalist contacts primary medical physician; orthopedic surgical team contacts surgical/referring physician</td>
<td>Both surgeons and hospitalists complete respective portions of discharge summary</td>
</tr>
<tr>
<td>Laboratory tests and medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveillance for and prophylaxis against deep venous thrombosis</td>
<td>Orthopedic surgical team</td>
<td>Surgeons complete discharge summary</td>
<td></td>
</tr>
<tr>
<td>Initial postoperative laboratory and medical orders</td>
<td>Orthopedic surgeons with standard postoperative order set</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Co-Management: Decreased cost

Table 2. Mortality Rate, Readmission, Length of Stay, and Costs Before and After CNS Implementation

<table>
<thead>
<tr>
<th></th>
<th>Before CNS Implementation</th>
<th>After CNS Implementation</th>
<th>Change After CNS Implementation (95% CI)$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality, %</td>
<td>104 (2.47)</td>
<td>88 (2.59)</td>
<td>0.97 (0.65-1.05)</td>
</tr>
<tr>
<td>Readmission after 30 days, %</td>
<td>277 (6.59)</td>
<td>192 (5.66)</td>
<td>0.83 (0.65-1.05)</td>
</tr>
<tr>
<td>Length of stay, median (IQR), d</td>
<td>5 (3.8)</td>
<td>5 (3.8)</td>
<td>0.97 (0.92-1.03)</td>
</tr>
<tr>
<td>Total costs, median (IQR), $</td>
<td>23,867 (15,133-40,966)</td>
<td>24,533 (15,881-41,943)</td>
<td>0.94 (0.88-1.00)</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; CNS, comanagement on neurosurgery service; IQR, interquartile range.
$^a$Values represent overall change in outcome in the 18 months after implementation compared with the precomanagement period. For mortality rate and readmission, the values are adjusted odds ratios; for length of stay and total costs, the values are adjusted rate ratios.

Co-Management: Decreased mortality

TABLE 4. Changes in Outcomes in the Intervention and Control Groups, Pre and Post-SCM (After Propensity Score Weighting)

<table>
<thead>
<tr>
<th>Outcome, %</th>
<th>Intervention Group (n = 16,930)</th>
<th>Control Group (n = 3695)</th>
<th>Adjusted Rates and Odds ratios (n = 20,625)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>Rate</td>
<td>Adjusted Odds Ratios for Effect of the SCM Intervention</td>
</tr>
<tr>
<td></td>
<td>Pre, % (n = 12,740)</td>
<td>Post, % (n = 4190)</td>
<td>Odds Ratio (95% CI)*</td>
</tr>
<tr>
<td>Patients with &gt;1 medical complication</td>
<td>9.5</td>
<td>8.0</td>
<td>0.83 (0.70–0.95)</td>
</tr>
<tr>
<td>Patients with LOS &gt;5 d</td>
<td>28.4</td>
<td>21.2</td>
<td>0.72 (0.59–0.91)</td>
</tr>
<tr>
<td>30-d readmission for medical cause</td>
<td>3.0</td>
<td>1.8</td>
<td>0.63 (0.54–0.90)</td>
</tr>
<tr>
<td>Patients with &gt;2 medical consultants</td>
<td>14.5</td>
<td>8.8</td>
<td>0.59 (0.50–0.67)</td>
</tr>
<tr>
<td>Patient satisfaction (top-box)</td>
<td>89.0</td>
<td>92.9</td>
<td>1.05 (0.86–1.27)</td>
</tr>
</tbody>
</table>

*All analyses compare pre-to-post differences (pre represents January 2009–July 2012, before SCM model; post represents September 2012–September 2013) between intervention and control groups. All models were adjusted for age, sex, race, marital/partner status, annual income, primary insurance, medical history, case mix index, Charlson comorbidity index, ASA score, surgical department, surgical diagnoses-related group, elective or emergent surgery, general or regional anesthesia, operating time, patient’s admit source, and the place of discharge.

†Medical complication: sepsis, pneumonia, urinary tract infections, delirium, acute kidney injury, atrial fibrillation, or ileus.

‡Patient satisfaction survey response rates were 24.9% and 27.8%, respectively, in the pre and postintervention groups, and 24.1% and 32.8%, respectively, in the pre and postcontrol groups.
Co-Management: Decreased mortality

Question 5: What is your primary mode of communication with your hospitalist?

a) Phone
b) EHR
c) Faxed Discharge Summary
d) Don’t Have One
Communication and Transitions of Care: Ineffective care transition processes lead to...

- Adverse outcomes for patients
- Decreased patient and staff satisfaction
- Inappropriate use of resources
- Financial penalties through reduction in reimbursement from the Centers for Medicare & Medicaid Services (CMS) and other insurers
Communication and Transitions of Care: What can Hospitalists do better?

• Contact the PCPs on admission and discharge
• Speak to a family member
• Ensure follow-ups are scheduled
• Improve documentation on discharge summaries
Communication and Transitions of Care: What we are doing at SLU?

• Have identified how our PCPs like to be communicated with
  • Phone
  • EHR routing of DC summary
  • EHR messages

• Built in area of discharge summary template indicating who was conveyed the hospital course
  • Once using the template, 100% compliance
  • Now trying to pass the importance on to the residents into their discharge summaries
# The 8P Screening Tool
## Identifying Your Patient’s Risk for Adverse Events After Discharge

<table>
<thead>
<tr>
<th>The 8Ps (Check all that apply)</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems with medications</strong> (polypharmacy – i.e. ≥10 routine meds – or high risk medication including: insulin, anticoagulants, oral hypoglycemic agents, dual antiplatelet therapy, digoxin, or narcotics)</td>
<td>- Medication specific education using Teach Back provided to patient and caregiver</td>
<td></td>
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<tr>
<td></td>
<td>- Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)</td>
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<tr>
<td></td>
<td>- Specific strategies for managing adverse drug events reviewed with patient/caregiver</td>
<td></td>
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<tr>
<td></td>
<td>- Elimination of unnecessary medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Simplification of medication scheduling to improve adherence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological</strong> (depression screen positive or history of depression diagnosis)</td>
<td>- Assessment of need for psychiatric care if not in place</td>
<td></td>
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<tr>
<td></td>
<td>- Communication with primary care provider, highlighting this issue if new</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Involvement/awareness of support network insured</td>
<td></td>
</tr>
<tr>
<td><strong>Principal diagnosis</strong> (cancer, stroke, DM, COPD, heart failure)</td>
<td>- Review of national discharge guidelines, where available</td>
<td></td>
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<tr>
<td></td>
<td>- Disease specific education using Teach Back with patient/caregiver</td>
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<tr>
<td></td>
<td>- Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms</td>
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<tr>
<td></td>
<td>- Discuss goals of care and chronic illness model discussed with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td><strong>Physical limitations</strong> (deconditioning, frailty, malnutrition or other physical limitations that impair their ability to participate in their care)</td>
<td>- Engage family/caregivers to ensure ability to assist with post-discharge care assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Assessment of home services to address limitations and care needs</td>
<td></td>
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<tr>
<td></td>
<td>- Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place.</td>
<td></td>
</tr>
<tr>
<td><strong>Poor health literacy</strong> (inability to do Teach Back)</td>
<td>- Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions</td>
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</tr>
<tr>
<td></td>
<td>- Post-hospital care plan education using Teach Back provided to patient and caregiver</td>
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</tr>
<tr>
<td></td>
<td>- Link to community resources for additional patient/caregiver support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td><strong>Patient support</strong> (social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care)</td>
<td>- Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
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<tr>
<td></td>
<td>- Follow-up appointment with appropriate medical provider within 7 days after hospitalization</td>
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<td></td>
<td>- Involvement of home care providers of services with clear communications of discharge plan to those providers</td>
<td></td>
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<tr>
<td></td>
<td>- Engage a transition coach</td>
<td></td>
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<tr>
<td><strong>Prior hospitalization</strong> (non-elective; in last 6 months)</td>
<td>- Review reasons for re-hospitalization in context of prior hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Follow-up appointment with medical provider within 7 days of hospital discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Engage a transition coach</td>
<td></td>
</tr>
<tr>
<td><strong>Palliative care</strong> (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness? “No” to 1st “Yes” to 2nd = positive screen)</td>
<td>- Assess need for palliative care services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Identify goals of care and therapeutic options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Communicate prognosis with patient/family/caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Assess and address concerning symptoms</td>
<td></td>
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<tr>
<td></td>
<td>- Identify services or benefits available to patients based on advanced disease status</td>
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<tr>
<td></td>
<td>- Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient</td>
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</tr>
<tr>
<td>I was in the hospital because</td>
<td>If I have the following problems ...</td>
<td>I should ...</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td>1.</td>
<td>1.</td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>(____) _______</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td>2. My hospital doctor:</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td>(____) _______</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
<td>3. My visiting nurse:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(____) _______</td>
</tr>
</tbody>
</table>

My appointments:

1. On: _/__/at ___: ___ am/pm For: ______
   On: _/__/at ___: ___ am/pm For: ______
2. On: _/__/at ___: ___ am/pm For: ______
3. On: _/__/at ___: ___ am/pm For: ______
4. On: _/__/at ___: ___ am/pm For: ______

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
5. __________________________________________

I understand my treatment plan. I feel able and willing to participate actively in my care:

_________________________________________  ____________
Patient/Caregiver Signature                  Date

Provider Signature ___________________________
Communication and Transitions of Care: Other implementation ideas

• Identify discharge barriers on Day 1 of hospitalization
• Creating patient centered discharge instructions
• Engagement in home and community support programs
• Hospitalists staff discharge/transition of care clinics
• Rotate at SNFs/LTACs
• Pharmacist rounding regarding medication reconciliation prior to discharge
Communication and Transitions of Care: What can other physicians do better?

• Inform patients ahead of time that you will not be coming to the hospital but that they will be taken care of ‘X’ Hospitalists
• Call Hospitalists when sending patient to ED to give them some history (as it doesn’t usually get passed on)
• Tell Hospitalist team your preferred method of contact/notification - if by phone, give a back line
• Call the Hospitalist back
Looking Forward
Future of Hospital Medicine

• Projected growth
  • APPs
  • Increased specialty hospitalists
  • Medical Officers in the ED

• Scheduling changes
• Potential watch-outs
• Communication
  • EHR
Types of Hospitalists

• Traditional
• Academic
• Proceduralists
• SNFists
• Nocturnists
• Specialists
Keep pushing goals

• Decrease competing priorities
• Provide high value care
• Transitions of care
Burnout

- Illusion of free time
- Impacts of personal and professional times
- Work load
- Increasing demands of use
What’s new

• Billing code April 2017-’C6’
• Associations
  • SHM
    • Designations: FHM, SFHM, MHM
  • ACP Hospitalist
  • SGIM Hospitalist
What’s new

• Education
  • Hospital medicine fellowships
    • Administrative-1
    • Internal Medicine-26
    • Family Medicine-13
    • Pediatrics-26
  • ABIM-Focused Practice in Hospital Medicine
    • In place of traditional Internal Medicine exam
    • Must complete MOC credits as well
    • Must have practiced hospital medicine x 3 years with a certain number of inpatient encounters with a letter from a superior who can attest to your practice
Questions

• Thank you!