

**DRAFT**

# Hospitalist Program Models



Hospitalist Task Force  
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# Development Process

- Construction of draft – Krivenko, Antonucci, Greenberg, Kole – 10/14/09
- Legal review – 10/16/09
- Board input – 10/19/09
- Physician input – (Drs. Brust and Rios)

# TF Actions

- Administration to develop a list of standards and accountabilities to be supported by the medical staff
- Develop criteria for assessing hospitalist performance to those the list of standards
- Develop a method of oversight of hospitalist's performance.
- Avoid exclusive contracts to permit choice of hospitalist within the medical community
- The medical staff will control access to unattached patients by review performances and assuring that coordination of care and good outcomes are achieved.

# Board Authority

- The Board wants the TF to understand that the ultimate responsibility for quality and safety lies with Board.
- The Board wants all patients, presenting to the institution in the care of a hospitalist, to know why he/she is caring for them and his/her credentials and experience
- The Board will review and oversee of the quality and safety of care given by hospitalists in the health system on a regular basis.

# Definition of a Hospitalist

A physician, who is part of a organized system of care, meaning a coordinated group working together, whose entire professional focus is the general medical care of hospitalized patients in an acute care facility and whose activities include patient care, communication with families, significant others, PCP, and leadership related to Hospital Medicine.

A physician who does not maintain an obligation or practice for patients in an ambulatory setting (i.e., outpatient office or clinic setting).

# Strategic Goals of the Health System

- All unassigned patient will go to hospitalists “in rotation” of each of the active hospitalists at each specific campus. Assignment process to be determined with consultation of the departments of medicine, but will only include physician defined as hospitalist.
- 12 month goal is to have contracted (non-exclusive) hospitalists groups admit all patients who are not attended by their personal physician or group.
- 12 month goal that all qualified contracted hospitalists in the system will be required to have a 24/7, in-house program

## Coverage Requirements (short-term)

- Arrange for qualified hospitalists to staff the Facility,
- Orient the hospitalists to their duties
- Monitor their performance to see that standard develop will be complied with in all respects.
- Meet volume, acuity, and patient satisfaction needs of the Facility
- Presence of an on-site physician for a minimum of 15 hrs (7am – 10pm) at each facility.

# Dress Requirements

- Hospitalists will agree to a dress code appropriate to their professional duties. Business casual attire is suggested.

# Communication

- Provide a brochure to all admitted patient introducing and describing the functions of the hospitalist group.
- Communicate with the primary care physician on admission, discharge and significant changes in a clinical condition.
- Communicate with PCP upon discharge and arrange to have the dictated discharge summary faxed to the PCP upon discharge.
- Prepare legible standardized progress notes
- Appropriate sign-off of clinical information between members of the group.
- Use of LMHS standardized order sets when possible.

# Consultations Management

- Limit the number of consultations to those necessary to achieve appropriate medical care for the patient.
- Work with consultant physicians to define clinical protocols that allow appropriate care and negate the necessity for consultations for commonly occurring conditions generally encountered by internal medicine Hospitalist physicians.
- Comply with the required telephonic communication physician to physician for all consultation requests.
- Admit pregnant patient under 20 weeks with a primary medical diagnosis
- Avoid requests for consultation prior to the hospitalist evaluating the patient, unless the situation is emergent as determined through consultation with the attending ED physician.

# Discharge Coordination

- Work directly with the consulting physicians to determine the appropriate date for discharge.
- Eliminate all D/C dependency on consultants (D/C if OK with...)
- Work within hospitalist physician duties to accomplish a discharge order by 10 a.m. daily to effect a patient discharge by 3 pm

# Care Management

- Work directly with case management department to identify patient care options that facilitate the clinical and social recovery of the patient.
- Collaborate with the hospitalist group or groups then providing services at any other hospital facilities for appropriate communication and transfer arrangements prior to the actual transfer of the patient.

# Response Times

- Response time, in person when requested, to Emergency Department, Critical Care Units, and Progressive Care Units within 30 minutes of request for assistance, including overnight.
- Response time, in person when requested, to Medical/Surgical units within 60 minutes of request for assistance.
- Detailed written process for back-up coverage for situations when primary Hospitalist does not return calls and for situations when primary hospitalist has multiple admissions pending simultaneously and inpatient services require hospitalist attention.

# Documentation

- Achieving greater than ninety five percent (95%) completion of coding queries on active admissions to improve the accuracy of coding and to facilitate accurate categorization of clinical disease.
- Achieving greater than ninety five percent (95%) completion of dictations of H & Ps and/or approved Discharge Summaries within 24 hours of discharge order.
- Understand that each sections of the medical record should stand alone and should be an integral, cohesive part of the plan of care (do not copy consultant notes to the H&P).

# Capacity

- Maintaining a patient census that does not, on average, exceed 20 patients per hospitalist per day.
- Adjust and reduce patient load to match the demands of critically ill patients.
- Variances due to unusually high admission or discharge activity are acceptable as long as the patient load limitations are adhered to in a good faith manner.

## Minimum Qualification/Eligibility Requirements

- Board Certified in Internal Medicine or Family Practice or eligible to be admitted to the certification process and able to achieve board certification within the timeframe set forth in the Medical Staff Bylaws for the specialty of Internal Medicine or Family Practice.
- Credentialed by System.
- If *locum tenens* status, physician must meet the credentialing requirements of the LMHS Medical Staff Bylaws for the specialty of Internal Medicine or Family Practice prior to any patient contact.
- Maintain all customary narcotics and controlled substance numbers and licenses.

# Scorecards Suggestions

1. Pt satisfaction HCAPHS
2. Discharge Notification rates
3. Late medical records
4. Core Measures compliance
5. NPSG – med reconciliation, abbrev,
6. Stroke care compliance order sets
7. LOS
8. Mortality
9. Blood Management
10. Census management
11. % of discharges before 11



Comments?

Questions?

Next Steps?