Credentialing hospitalists
The rise in the number of hospitalists has forced hospitals to consider how best to credential and privilege them. Learn how to avoid reinventing the wheel on pp. 8–11.

In the news
One poll found that consumers think electronic medical records could improve healthcare—and they're willing to pay for it. Details on p. 11.

Q&A: Are there hospitalist fellowships?
This month, our “Ask the expert” feature tackles a reader’s inquiries about hospitalist fellowships and reimbursement. To learn the answers, check out p. 12.

Hospitalists key to ensuring seamless patient discharges
Of all the bases that hospitalists cover—from assuming responsibility for patients referred by their primary care physicians (PCP) to communicating with families and other healthcare professionals—the steps they take during the discharge process may leave the strongest impression on patients.

Experts say physicians often view releasing a patient as an afterthought to the delivery of care. However, the issues related to effective patient discharge and transition from one level of care to another are significant, and they affect the following:

- Level of cost savings related to length of stay (LOS)
- Strength of existing communication systems between hospitalists/PCPs, hospitalists/other providers
- Percentage of patient readmission rates
- Quality of care postdischarge (e.g., follow-up visits and tests)

“An effective discharge process, which begins at admission, will shorten length of stay and dramatically impact readmission.”

Hospitalists and the digital hospital
While technology has transformed industries like banking and even consumer purchases over the past 20–30 years, the healthcare industry finally has begun to catch up over the past few years.

Experts agree that hospitals large and small are beginning to implement more technology into their systems. Many have adopted computerized physician order entry, electronic medical records (EMR), or other technology to improve quality of care, patient safety, efficiency, and costs.

However, there’s more to being digital than implementing one or two of the leading computerized healthcare technologies in your facility, says Mary Jo Gorman, MD, MBA. Gorman is chief medical officer for IPC (www.ipcm.com), a large private-practice hospitalist company headquartered in North Hollywood, CA.

She notes that although some organizations may consider themselves digital once they have implemented an electronic radiology system, only a handful of truly all-digital hospitals exist.

Note: The Oklahoma Heart Hospital (www.okheart.com) in Oklahoma City, which
Seamless discharge

rates,” says Adam Singer, MD, founder and chief executive officer of IPC (www.ipcm.com), a private-practice hospitalist company headquartered in North Hollywood, CA.

The discharge process occurs at a time when the patient is most vulnerable because he or she is transitioning to a less intense level of care following an acute episode. And although hospitalists are accustomed to moving a patient effectively and efficiently through the acute episode within the hospital, there must be an established method of communicating with the PCP postdischarge to achieve the hospitalist program’s goals, says Jackie Birmingham, RN, MS, CMAC, vice president of professional services for Newton, MA–based Curaspan (www.curaspan.com), which offers an Internet-based discharge-planning tool.

The following are steps hospitalist programs are taking to ensure effective communication during discharge.

Establishing, maintaining effective communication

Poor or ineffective communication during discharge is not only bad business for a healthcare organization, but it could lead to disastrous effects on a patient’s care following hospitalization. Many communication issues depend on the mechanisms jointly created by the healthcare organization, hospitalists, and PCPs in each community, according to Birmingham.

She says the following questions should be addressed either in the hospitalists’ contract or in the hospital’s job description for hospitalists:

- What are the hospital’s rules for assigning a patient to a hospitalist?
- Is the hospitalist responsible for the discharge summary? There are rules about completion of a discharge summary, but for some patients, determining when the discharge summary should be written and distributed is critical
- Is the hospitalist responsible for interacting with insurance companies that perform utilization review at the hospital?
- Is the hospitalist responsible for writing discharge orders? Will he or she be responsible for completing the paperwork necessary to make a referral to a home health agency or a skilled nursing facility?
- Is the hospitalist responsible for tracking and communicating results of tests ordered and done pre-discharge and the test results returned after a patient is discharged?

Stefani Daniels, RN, MSNA, CMAC, founder and managing partner of Pompano Beach, FL–based case management consulting firm Phoenix Medical Management (www.phoenixmed.net), explains that when ineffective communication is the norm among hospitalists and others responsible for patient care, the resulting problems reflect negatively on both the clinical care team and the hospital.

Federally mandated discharge procedures

The JCAHO recently sharpened its focus on the discharge process, addressing the topic in its 2006 National Patient Safety Goals for hospitals (www.jcaho.org/accredited+organizations/hospitals/npsg/06_npsg_cah_hap.htm), which aim to improve communication among healthcare providers.

Specifically, Goal 2E states that hospitals must “implement a standardized approach to ‘hand off’ communications,” which includes providing patients the opportunity to ask questions and physicians an adequate opportunity to respond to concerns.

In addition to individual state regulations and the JCAHO standards for continuity of patient care, the Society of Hospital Medicine (www.hospitalmedicine.com), the American Medical Association (www.ama-assn.org), and the American Academy of Family Physicians (www.aafp.org) publish recommendations for hospital discharge planning (see sidebar on p. 5).
“One of the biggest problems we find is that the physician says one thing to the patient and family members with regard to post-acute services, and the case manager will discover that the scenario is not possible given the patient’s benefits or resources,” she says. This often results in case managers and other providers having to correct misinformation, smooth the ruffled feathers of patients’ families, and explain why plan A will not work and plan B is the more appropriate path, she says.

Daniels says that to promote seamless patient handoffs, one of her company’s clients ensures that PCPs receive their patients’ discharge summaries within 24 hours of the patient leaving the hospital. The process was developed by the case managers at the hospital with the help of the medical records department and the health information management (HIM) office.

“The hospitalists made the commitment to dictate discharge summaries within the set time frame, and the HIM department made the commitment to get the summaries transcribed and in the hands of case managers, who . . . would see that the community physicians received the information,” Daniels explains.

Fast-turnaround discharge summaries not only bettered patient care at the hospital, but also strengthened the relationship between its PCPs and hospitalists. “It’s another step toward saying to community physicians, ‘We’re not here to compete with you or steal your patients. We’re here to help you provide the best care possible,’ ” says Daniels.

Ensuring effective communication is the basis for IPC’s transition management program, which is one facet of the information the company provides its hospitalists during an initial 13-week training program.

“We teach our physicians to contact the PCP three ways: by phone, with a dictated discharge summary through the hospital, and with a fax discharge summary through IPC’s Internet system,” Singer says. In addition, IPC hospitalists also contact patients two days postdischarge.

Note: Singer says IPC has developed a process to monitor patients’ progress at seven predetermined intervals that, although redundant, helps hospitalists and nurses intervene before bad outcomes can occur. As a result, Singer says IPC hospitalists experience readmission rates far below the national average.

William Cheng, MD, is the director of the hospitalist program at the Palo Alto (CA) Medical Foundation (PAMF), which serves nearby Stanford Hospital. He believes having hospitalists who are employed by the foundation, as opposed to being a contracted group, makes communication easier.

“It’s harder for independent hospitalists or contract groups to try to track down PCPs and leave voice-mail messages. When one of our patients is discharged to a nursing home, for example, it’s almost always to the care of one of our PCPs,” he says.

According to Cheng, the use of electronic medical records (EMR) at PAMF has also helped foster better communication at discharge. When hospitalists discharge a patient, the policy is to immediately create a summary of the care detailed by the EMR system, he says. The data contained in a patient’s EMR include important lab results, medication changes, referrals, and follow-up test orders.

**Monitoring troublesome points postdischarge**

Cheng singles out communication about medication changes as one potentially troublesome area. He says patients often don’t fully understand what their medication changes are posthospitalization. As a result, he recommends that hospitalists pay particular attention to medication management.

“Electronic medical records have helped, but it’s something we continually monitor,” he says. Other improvements PAMF is working on include longer-term follow-up procedures with PCPs on x-ray abnormalities. “For example, we want to make sure that the PCP knows to recheck in six months . . . is necessary to ensure that [the condition] is not progressing.”

Birmingham agrees that many organizations could improve their medication communication. She recalls an example of a patient who was taking...
Seamless discharge

three heart medications simultaneously posthospitalization because of miscommunication between caregivers. One medication was prescribed by her prehospital cardiologist, one was prescribed by the hospital cardiologist, and one was a generic equivalent that the patient thought was another new medication. Birmingham caught the error when the patient’s daughter called and requested a wheelchair.

“I knew she shouldn’t have needed a wheelchair at that point . . . In this case, everybody was involved but no one was accountable,” she says.

Note: Under the JCAHO’s medication standard MM 8.10, hospitals must institute and document a process to help identify risks associated with medication management, including preparation, labeling, storage, and administration of medications.

Case manager/hospitalist partnerships

Daniels says she “jumps for joy” when she discovers that a new hospital client has a hospitalist program. “Hospitalists are the one group of physicians, after interns and residents, who are the most amenable to forming partnerships that will help them in managing the care of their patients,” she says.

She says hospitalist/case management partnerships began popping up nationwide about three years ago. Daniel supports such partnerships and advises hospitals with limited resources “to put in place a hospitalwide case management program, at a minimum, assign the case managers that you have to the hospitalists.” She cites hospitalists’ interest in the business side of managing care as the primary reason hospitals should consider the idea.

Although case managers can be a great help to hospitalists in facilitating a smooth discharge process, Daniels says the discharge process begins well before the patient is ready to leave the hospital.

According to Daniels, from the outset of the patient’s hospital stay, providers should consider what

- the hospital is trying to achieve for the patient
- outcomes should be anticipated
- milestones will identify when the patient is ready to move to the next level of care
- the case manager must do to plan for the duration of the patient’s care

Birmingham says she believes that the increasing number of partnerships between hospitalists and case managers shows an evolution of “follow the money” in healthcare.

“Is the hospitalist’s performance being evaluated in terms of LOS, better discharge planning, fewer complications, or cost per case? For any of these criteria, it speaks volumes about the need for case managers,” she says.

Seizing the opportunity to involve patients

Birmingham says hospitalists are naturally focused on the accuracy of a patient’s diagnosis and the resulting response to interventions (e.g., surgery, medications, therapies) by virtue of their specialization in inpatient care. However, there may be many more opportunities to improve outcomes, such as return to emergency room rates.

She recommends that hospitalists, along with the case manager, interview the patient to confirm what physician or specialist he or she will see next, and document the answer in the discharge summary.

“[Hospitalists or] case managers shouldn’t assume it’s going to be the PCP. The patient may have an appointment with a surgeon first and not see their PCP until three months later,” she says.

Editor’s note: The federal standards for discharge planning can be found at www.ssa.gov/OP_Home/ssact/title18/1861.htm. Search for “discharge planning,” and it will take you to § 1861 (ee).
The Society of Hospital Medicine (SHM), the nation’s largest society for physicians who practice hospital medicine, publishes advice for patient discharges in a section about “continuity of care” on its Web site (www.hospitalmedicine.org). It states, “A dictated summary of the hospitalization should reach the [primary care physician (PCP)] as soon as possible, so that the PCP has it in hand before the patient comes in for follow-up. The information that needs to be conveyed should deal with medications, timing of follow-up, labs, and other tests that may be needed or required.”

The SHM also cites legal hand-off issues at discharge, noting that some hospitalists—in addition to recording the appropriate information in the patient’s medical record—note in the hospital chart that they have spoken with the PCP, faxed a discharge summary, or left a voicemail message to further ensure a smooth handoff of the patient back to the PCP.

Finally, the society notes the most common mechanisms hospitalists use to communicate information to PCPs at discharge:

- **Preprinted discharge forms** to be filled out by the hospitalist (i.e., multiple-copy form, with one copy for the hospital chart, one for the patient, one for the pharmacy, and one for the PCP.

- **Hospital-dictated discharge summaries**, Although it’s noted that these can be sent to the PCP only if the hospital dictation system includes a “stat” option, as discharge summaries often can lag weeks.

- **Last hospital notes** faxed to the PCP and to summarize the hospital course and outpatient recommendations.

- **Telephone calls or voicemail message.** This provides an opportunity for the hospitalist and the PCP to talk directly about the course of hospitalization and any unresolved issues, but the downside is there is no paper record.

- **E-mail.** A recent national survey found that hospitalists were currently using e-mail for this purpose, but clearly this is a possibility for future communication strategies.

**Digital hospital**

opened August 2002, and the Indiana Heart Hospital (www.hearthospital.com) in Indianapolis, which opened in February 2003, are considered among the first all-digital hospitals in the United States and boast no paper records. Instead, all patients’ medical records are scanned into the computer upon their arrival.

“To really optimize technology in the hospital, you have to tie in lab results, computerized physician order entry, and various patient parameters in such a way that the computers compensate for our brain weaknesses,” Gorman says.

Because patients receive care from so many providers in the hospital, one of the biggest advantages of being digital is the ability to collate a large volume of information and present it to physicians in a quick and efficient manner, she contends.

However, according to Gorman, the challenge for hospitals to go digital is the high costs; most hospitals are a long way from being able to make those investments and then make them pay off. Regarding technology, she says, “Hospitals lag many other industries. If you can go to a grocery store and pay with a credit card in less than five seconds, why wouldn’t you be able to have your medications checked in a hospital?”

**Advantages of going digital**

Thaddeus Franklin is the director of the hospitalist program at DeKalb Medical Center at Hillandale (www.dekalbmedicalcenter.org) in Lithonia, GA. DeKalb, the first digital hospital in Georgia,
opened its doors to patients July 18.

Franklin says that in addition to features such as EMRs and remote access for physicians to patient information (e.g., x-rays, radiology, alerts, and lab reports), the facility has Internet portals in every room.

“The system enables physicians to view the actual documents in the patients’ medical records,” which are scanned in, he says, as opposed to just reading summaries of reports. DeKalb Medical Center at Hillandale’s three-hospital parent health system—DeKalb Medical Center—has invested $20 million systemwide in wireless infrastructure and clinical technologies. DeKalb Medical Center plans for its two other hospitals to be all-digital within five years.

In Franklin’s view, digital hospitals like DeKalb Medical Center will
- streamline patient care
- increase staff efficiency
- eliminate test duplication
- provide overall enhancements to patient safety

Olufunso Ojo, MD, a hospitalist at DeKalb, sees great potential for the digital hospital to better almost any treatment protocol. “With the computer technology we have in place, there is almost no way [a physician] is going to miss any potential treatment options.” He notes that the technology enables physicians to have at their fingertips access to information about nearly every medical condition known.

Gorman agrees, noting that if a physician orders a lab test on a patient and the test comes back abnormal, today’s technology will even suggest treatment options. “Computers are good at comparing a lot of data points and following rules. For example, if you start a patient on an antibiotic and [his or her] kidneys won’t tolerate it, the computer will give you a message to that effect,” she says.

**A good fit: The youth factor and technology**
Franklin, who notes that DeKalb has approximately 15 hospitalists working in the medical center’s three sites, says he believes the relative youth of most hospitalists (their median age is 37, according to the Society of Hospital Medicine) is likely a factor in why hospitalists are a good fit in digital hospitals. “Hospitalists are on average younger than other physician specialists and, in our experience, are already [well-versed] in the use of all kinds of technology—from e-mail to Palm Pilots™ to tablet [personal computers],” he says.

Further, he stresses that DeKalb’s hospitalists are at the forefront of setting the standards and standardizing the procedures at the organization. He believes that is the case in other hospitalist programs in all-digital hospitals as well, in part due to their constant presence in the facility.

Gorman, whose company currently places hospital-
ists in 15 markets nationwide and collectively manages more than $1 billion in healthcare expenditures each year, provides an example of how she has seen hospitalists react to new technology. “When someone comes into the healthcare facility and says, ‘We’re putting in computerized physician order entry,’ the hospitalists say, ‘Great; no problem.’ They go through the training course, they start using it, and that’s the end of it.”

Meanwhile, she says, many others on the medical staff panic or initially view the implementation of any new computerized system as a hindrance.

What may be even more important than hospitalists’ willingness to accept and embrace the use of various new technologies in digital hospitals is the fact that they have become the “super-users” in many facilities, Gorman says.

“They are the ones who become familiar with the systems first—partially because they are in-house all of the time—and then they become a great teaching resource to many others on the staff.”

Using the digital factor as a recruiting tool
Judging from recent data on the number of practicing hospitalists compared with the explosive demand for these professionals (see sidebar on p. 6), chances are good that your hospitalist program has found recruitment a challenge in today’s hot job market.

While it might logically follow that digital hospitals are using the advantage of being digital to attract and recruit hospitalists, Gorman says a couple of factors appear to be preventing hospitals from using it as a recruiting tool thus far.

First, according to Gorman, many physicians who are hospitalists still view the use of more computers in the hospital as a negative. Because they are so new, digital hospitals may not have figured out a way to use this to their advantage when recruiting hospitalists, while simultaneously attracting other physician specialists. When they hear about a new healthcare technology, many physicians feel that “it’s just one more software program they will have to learn,” she notes.

On the other hand, this may change in the future as more residency training programs implement new technology mirroring that appearing in digital hospitals. For the few physicians coming out of training programs with advanced, well-established digital systems, she says it may be important for them to have all-digital technology in the hospital where they are employed.

The second factor, according to Gorman, is physicians’ mindset with regard to what is important when looking for a job. With so few truly all-digital hospitals in the United States today, seeking out work at one may mean a big move or a major change in lifestyle. She notes that the following factors may currently rank higher on a physician’s lists than being digital when considering a position:

- geographic location to be near family
- practice situation, hours, and staffing model
- network of partners with whom the physician would be working
- quality of the nursing staff and other healthcare providers at the site

Franklin says DeKalb had a well-established hospitalist program that attracted physicians from nearby Emory University Medical School even before the facility went digital. Nonetheless, he says, “Being completely digital will be . . . a tremendous help in recruiting new physicians,” he says.

Illustration by David Harbaugh

“I’m not a hospitableist—you’re confusing me with a receptionist. I’m a hospitalist. I practice medicine.”
Six credentialing and privileging considerations

Hospitals struggle with myriad issues when starting and managing a hospitalist program because it is new territory for many, but experts say one of the most frequently misunderstood areas is the credentialing and privileging of hospitalists.

Specifically, the increasing presence of hospitalists has forced hospitals to consider whether they should deviate from standard practices when hiring, credentialing, and privileging these professionals.

Experts say the procedures followed when credentialing hospitalists should be the same as those followed when processing membership and privileging requests from all other physician applicants, even though a hospitalist’s specialty is organized around a site—the hospital—rather than an organ (cardiology), disease (oncology), or population (geriatric medicine).

However, it is not always so simple. Whatever the stage of your organization’s hospitalist program—in development, nascent, or well established—the following are unique issues that hospitals continue to face when tackling this credentialing task.

Issue 1: Categorizing hospitalists with respect to bylaws and credentialing, privileging procedures

Sandi Zajack, CPCS, physician services coordinator for MedCentral Health System in Mansfield, OH, has worked with hospitalists for five years. She notes that her organization has approximately 12–15 hospitalists—including full-time, part-time, and locum tenens—working within the system.

Note: MedCentral does not directly employ its hospitalists, but rather uses contract physicians through Canton, OH–based Hospitalists Management Group, Ltd. (www.hmgdoc.com).

Zajack says she’s seen colleagues panic when they learn that their hospitals are implementing a hospitalist program. Such announcements often cause medical services professionals (MSP) to worry that they must quickly develop procedures for credentialing and privileging these professionals. However, she stresses that there’s no need to reinvent the wheel; her simple answer has been to consider hospitalists as internists.

“We haven’t tried to separate them out or treat them any differently when it comes to credentialing and privileging. Hospitalists are members of the internal medicine department at MedCentral and, as such, are subject to the same bylaws, rules, and regulations as other medical staff members,” she says.

According to Aaron Gottesman, MD, FACP, director of hospitalist services at Staten Island University Hospital and clinical assistant professor of medicine at SUNY Brooklyn, both in New York, another challenge of having a hospitalist program from a credentialing standpoint is deciding under which department’s jurisdiction they will fall.

Gottesman says at his organization—a large teaching hospital with 24/7 coverage by 17 full-time and two part-time hospitalists—the department of medicine participates in the credentialing of hospitalists. However, he asserts that the department of medicine doesn’t take on such complex issues as length of stay and utilization.

SHM guidelines

Although the Society of Hospital Medicine does not publish formal recommendations for credentialing and privileging hospitalists, in its recommendations for establishing a hospitalist program (www.hospitalmedicine.org) it states:

Opponents of the hospitalist model will be looking for a way to denigrate your program. It is very important to recruit physicians with the training, experience, credentials (e.g., board certification), and bedside manner that can make them not just as good as the existing medical staff, but as potential role models in the arena of hospital medicine.
“Hospitalists’ primary responsibilities actually lend themselves toward administrative goals. However, that credentialing category—administrative physician—doesn’t exist,” he says. Regardless of what department ultimately credentials hospitalists, he notes that their dual role in this respect and their unique perspective about a hospital’s business issues warrants consideration when deciding what department should host them.

Richard Rohr, MD, is director of the hospitalist service at Milford (CT) Hospital and a member of his hospital’s credentialing committee. His hospital currently employs five hospitalists and has maintained a hospital medicine program for four years. With regard to credentialing and privileging hospitalists, he contends that it is inappropriate to place hospitalists in a courtesy category on the staff or to assign them non-voting status.

“They are in fact the most active physicians on the hospital’s staff, and I think that any hospital that refuses to credential them as members of the active staff in the appropriate department is just not dealing with reality,” he says.

**Issue 2: PCPs affected by hospitalists’ credentials**

Hospitals that don’t take caution in planning for the effects of a hospitalist program on primary care physicians (PCP) could leave these practitioners feeling that they’re out of the loop.

As hospitalist programs proliferate, more PCPs place their hospitalized patients under the care of hospitalists. Although there was talk in the early days of the hospitalist movement about having PCPs pay social visits to their inpatients, the overwhelming majority of PCPs simply do not come into the hospital at all anymore, says Gottesman.

“It’s important not to lose the support of your PCP base,” says Gottesman. Assure them “that, despite not admitting to the hospital, they can still maintain their staff membership or privileges within the department of medicine.”

He notes that every hospital will approach the issue in its own way, but he suggests looking into the creation of a new category of membership—such as “ambulatory physician”—to maintain strong ties between PCPs and hospitals.

“The definition of ‘active physician’ has to change so that all physicians who are stakeholders have the opportunity to participate in the affairs of the hospital,” says Rohr. The criteria for active staff membership should be that physicians come to staff meetings regularly and participate on committees. “Clinical privileges should be dealt with as a separate...
Six considerations

issue,” he adds.

Zajack says that at MedCentral Health System, family practitioners for the most part have turned over the care of their hospitalized patients to hospitalists. However, she recognizes that for many PCPs, giving up staff privileges is not easy. “We knew it was going to be an issue shortly after our hospitalist program was started, so the family practice department met to discuss it and review what criteria would be needed in order to maintain staff privileges,” she says.

Although most PCPs affiliated with MedCentral do use the hospitalists, Zajack says she found it interesting that nearly all still decided to meet the organization’s criteria of caring for 10 adult inpatients over a 24-month period to keep their staff privileges.

“I don’t know if it’s insurance-driven or the fact that they have been on staff for 15–20 years and found that hard to give up,” she says.

Although the problem has been resolved at her organization, Zajack has seen other hospitals create “affiliate” categories for physicians who want to remain on staff but who simply do not admit the required number of patients annually. In essence, they would maintain staff membership but might not be eligible to vote or run for staff officer positions, for example.

Issue 3: Using contract hospitalists with privileges at multiple sites

Although Zajack’s health system uses a contract hospitalist company, the job of credentialing and privileging the hospitalists on staff still falls under her jurisdiction. She says it is important for her to maintain control over the process, but the issue that poses the biggest challenge is the time-consuming task of verifying the privileges of contract physicians who have worked at many locations.

“The company we use calls them ‘firefighters’ because they constantly move around to different facilities putting out ‘fires.’ The problem is that some of them have had privileges at 20 or 30 hospitals, and we have to verify every single one,” she says. Notably, the human resources department at MedCentral is not involved in the process. “I’m it for the medical staff,” she adds.

There’s no simple answer to cutting down the workload in these cases, and MSPs are ultimately responsible for verifying practitioners’ credentials and privileges. However, when it comes to the initial data collection phase, experts say the burden should be on the physician applicant. At that stage, he or she is responsible for ensuring that the hospital receives all of the requested information used to process a physician’s application.

Issue 4: Sweeps clauses in legal contracts

Rohr, who spoke about the economic and legal aspects of the hospital/hospitalist relationship during the Society of Hospital Medicine’s (www.hospitalmedicine.org) annual meeting in Chicago in April, notes an interesting issue related to the use of nonhospital-employed physicians.

He says “sweeps clauses” can be found in most hospitals’ bylaws and have been used in the past in conjunction with contract anesthesiology and radiology groups. Now, with many hospitals opting to contract out rather than build a hospitalist service, the clauses could become applicable in hospital medicine.
Specifically, sweeps clauses state that when a physician group’s contract with a hospital or healthcare organization expires, so do the privileges of the physicians within the group at that particular organization.

“They are aptly named in that, essentially, they enable a hospital to ‘sweep out’ a group of contract physicians when they bring in a new group,” he says.

**Issue 5: Granting special, expanded privileges**

At Staten Island University Hospital, there is a specific hospital medicine subdivision whereby members of the department of medicine review the applications and submit recommendations to the credentials committee, says Gottesman. For this type of program format, the requirements are highly variable and often depend on whether the hospitalist is at a large teaching facility or a small community healthcare organization, he says.

Programs that are more invasive or interventional may include hospitalists who are more hands-on in terms of putting in central lines, intubating patients, and inserting chest tubes—many tasks usually done by residents and fellows, says Gottesman. Other programs are completely noninterventional.

“It not only varies by hospital and by program, but it’s a distinct issue beyond just what department the hospitalists are credentialed under. It extends to their function in the program and the nature of the procedures for which hospitalists are requesting privileges,” he says.

**Issue 6: Mapping the goals of the program**

Although establishing the mechanisms for credentialing and privileging hospitals might seem like an issue to address after initiating a hospitalist program, Gottesman says he believes it behooves hospitals to think ahead about these issues even before bringing hospitalists on board.

“The overarching issue is defining the roles, goals, and expectations of the hospital and the hospitalists so there are no misunderstandings as the program grows,” he says. “That begins with defining expectations. For example, hospitals should decide at the outset whether the expectation is simply to provide a rounding feature for covering PCPs who no longer come into the hospital, or if it will include that as well as providing hands-on interventions,” Gottesman adds. Doing so, he notes, will ensure that those hired anticipate that the program will likely evolve over time.

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**Most consumers think the use of EMR could improve healthcare**

According to a survey released July 20 by Chicago-based management consulting firm Accenture (www.accenture.com), most consumers believe that electronic medical records (EMR)—especially when used in hospital emergency departments (ED)—could improve overall medical care, reduce the incidence of treatment errors, and be especially valuable during medical emergencies.

The survey captured responses of more than 500 healthcare consumers nationwide.

Specifically, Accenture found that the majority of individuals polled believe EMR has the potential to
- improve the quality of care (93%)
- reduce the number of treatment errors in hospitals (92%)
- lower healthcare costs overall (75%)
- reduce the amount of time patients spend waiting in physicians’ offices and the ED (78%)

The survey also found that consumers do not appear to be as concerned about privacy and cost issues related to EMR as experts once thought. Specifically, 54% of respondents said they are concerned about the privacy and security of their paper records, which nearly matched the number (55%) who said they believe that EMR are more secure than paper. In addition, 52% of those polled said they would be willing to pay at least $5 per month to have their medical records stored in an electronic format.

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Ask the expert: Are there hospitalist fellowships?

Q: Our medical director is concerned because the insurers in our area have not recognized hospitalists as a specialty, and that is affecting some of the reimbursements. One of the reasons provided is that “there are no fellowships or board certifications” specifically for hospitalists. I understand that there is a fellowship in Minneapolis. Can you tell me of any others in the United States?

A: There are a handful of fellowships across the country, including the Mayo Clinic in Rochester, MN; the University of California, San Francisco; and the Cleveland Clinic Foundation in Cleveland.

Hospitalists, in large measure, are currently credentialed as internal medicine/primary care physicians. Technically, they are not specialists, and there are not yet specialty or certification opportunities.

As for reimbursement, insurers may not want to recognize the specialty nature of what hospitalists do.

The best way to address this issue is to track your data (e.g., length of stay, readmission rates, Joint Commission on Accreditation of Healthcare Organizations’ core measures, or any other quality benchmarks that your individual program tracks). If your program is doing well, demonstrate this to the insurers, and then talk about reimbursement.

Editor’s note: This question was answered by Jeffrey R. Dichter, MD, FACP. Dichter is a partner of Medical Consultants PC, a large internal medicine multispecialty group in Muncie, IN, and director of the hospitalist program at Ball Memorial Hospital in Muncie. He is a former president of the Society of Hospital Medicine and author of The Hospitalist Program Management Guide.

Do you have a question regarding your role as a hospitalist? Submit your “Ask the expert” questions to mcoler@hcpro.com.