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Called that PCP yet?

Communication with outpatient doctors is critical

If you think your job is done when your patients are discharged, think again. A study by IPC, the Hospitalist Company, of six months worth of discharges found that more than one-third of patients had issues arise within 72 hours of discharge, and one-fifth had new or worse symptoms or medication issues arise.

INSIDE ...

Those figures underline the need for hospitalists to keep tabs on their patients after discharge and facilitate their return to the care of their primary care physicians, says **Ken Epstein**, MD, MBA, director of medical affairs at IPC.

Epstein's study, which is being submitted for publication this summer, looked at data from 15,000 post discharge interviews with his company's patients in 10 cities and 100 hospitals over the course of six months.

At IPC, every patient is called between 48 and 72 hours after leaving the hospital. Patients who report symptoms to call center staff are triaged to a nurse, who then seeks more information.

Among the cases Epstein says he has data on was an 87-year-old woman in the hospital with congestive heart failure, renal failure, and other problems. She was called two days post-discharge by the IPC call center and the patient's daughter answered the phone. She reported that her mother was having trouble sleeping and had dark colored stools. The call was triaged to a call center nurse, who found with further questioning that the woman was also short of breath.

"The nurse was concerned about new GI bleeding and advised the daughter to call an ambulance and get her mother to the hospital," Epstein says. "There is a real risk of death if you don't catch these things."

Another case was a 37-year-old woman who was in the hospital for a mild fainting episode early in her pregnancy. When called after release, she reported she was experiencing palpitations and a very rapid heart rate while in the shower and after mild activity. She hadn't called her physician yet. The nurse called a cardiologist

and rather than waiting for three months for an appointment, got her in right away.

Among the findings in the IPC study:

• **38% of patients had health issues arise within three days of discharge.** Demographically, there is no difference by age. There were a slightly greater number of women reporting signs and symptoms than men. Epstein is unsure why this is since "I don't think women are discharged any more ill than men."

The most common issues the study found were: if there was pain involved, it was worse, or if there was an infectious diagnosis, the symptoms were worsening.

• **11.9% of patients reported new or worsening symptoms.** Patients whose self-perceived health status was fair or poor were more likely to report signs and symptoms they found troubling.

• **8.6% reported issues surrounding medications.** Epstein stratified medications issues by type: not filling or picking up a prescription; not understanding how to take a drug; or having a question or concern about the medication. He said that those younger than 60 were less likely to have filled a prescription, while those who were older were more likely to have issues understanding how to take their medications.

The most common reason for not picking up prescription is lack of finances and the high costs of drugs, says Epstein. One case involved a 46-year-old in the hospital for anemia and esophagitis. At home, he reported increasing fatigue, and increased abdominal and chest pain. He didn't pick up his Prevacid because it was too expensive. The nurse called the patient's primary care physician and arranged for him to get some samples. "He would never have known to go in to his doc for samples," Epstein says.

They won't call, so you should

Perhaps the most interesting -- and troubling -- issue Epstein found in his study was that patients who felt worse were no more likely to have made a follow up appointment with their primary care physician than those who didn't have worsening signs and symptoms.

'We need to take responsibility and make sure the patient gets that appointment. Until the patient gets into the primary care doc's office, that patient is the hospitalist's responsibility. Only when they make it to the office is our job done.'

Ken Epstein, MD, MBA,
Director of Medical Affairs
IPC, the Hospitalist Company

"The importance of this is that physicians assume that there is a safety net at discharge," says Epstein. "We tell patients that if they feel worse to call their primary care doc. Then we assume they will make that call and go in if they do, in fact, feel worse. But that assumption doesn't hold true."

Indeed, of the patients who felt worse after two days, 61% had made a follow up appointment for within the next two weeks. Of those who felt well, 58% had made appointments. "But look at it the other way around: 40% didn't make appointments despite feeling worse," Epstein says.

The message, he says, is that you need a post-discharge transition system that doesn't assume patient will do what you tell them to.

"Have a post-discharge clinic or a system of calling them," he advises. IPC uses its call center and triaging system. If a patient has a problem the nurse deems critical, she'll have the patient call 911. If the nurse thinks it is serious but not critical, she will call the primary care physician and get the patient scheduled for an appointment in the next 48 hours. The added bonus of having a nurse or physician do that follow up is that the primary care physi-

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cian's office may respond more quickly to a nurse or doctor and ensure that the patient gets in to see his or her physician in a timely manner.

"We need to take responsibility and make sure the patient gets that appointment," Epstein says. "Until the patient gets into the primary care doc's office, that patient is the hospitalist's responsibility. Only when they make it to the office is our job done."

At the 2004 Society of Hospital Medicine meeting in New Orleans, Epstein says he had physicians tell him they would "try to call" patients. "But that's not good enough. It shouldn't be at the mercy of the hospitalist to remember to call. You have to find the time and do it, or create a system to do it for you."

Plenty of evidence to illustrate need

There are plenty of cases to illustrate the need for good communication between inpatient and outpatient physicians, says **Sunil Kripalani**, MD, MSc, an assistant professor at Emory University School of Medicine. He heard of a CHF patient who was discharged with several new medications. "The patient's usual caregiver was out of town at the time of discharge," he says. "The patient, confused about the new regimen, went back to his old and inadequate set of medications. Not surprisingly, his symptoms recurred and he was readmitted."

Since there is increasing information that patients won't get in touch with their primary care physicians, perhaps that responsibility should devolve to the hospitalist. Kripalani says that in the above case, if the inpatient physician had contacted the outpatient physician about the medication changes, and set up an appointment with the outpatient doctor soon after hospitalization, this readmission could probably have been avoided.

"Outpatient physicians are expected to follow-up on labs and other tests that are pending at hospital discharge, reconcile medications -- what the patient is discharged on, versus what they were on before the admission -- and schedule additional tests and consults," Kripalani says. "Unfortunately, there are times when the outpatient physician isn't notified about exactly what he or she needs to do. Add to this the fact that the post-hospital period is an especially vulnerable time for patients as they continue to recover from their hospital illness. It can be a tough time with many adverse events."

Kripalani says he'd like to see the hospitalist contact the outside physician by phone on the day of the discharge and be the one to schedule a follow up appointment. The discharge information should be faxed to the primary care physician -- diagnoses, med list, and any specific follow up needs. The patient should get a copy as well. A detailed discharge summary should get to the primary care physician within a week. "A lengthy phone call isn't necessary," says Kripalani. "A couple of minutes would be fine."

Reduce readmissions with quick call

Most of all, the hospitalist needs to remember that his or her responsibility for the patient doesn't just end when the patient walks out the door. Like Epstein, he believes that until that patient is "back in the hands" of his or her regular doctor, he or she is still the hospitalist's patient.

"Call the patient two or three days after discharge and make sure he or she is doing well," he says. Make sure the patient got the discharge medications and hasn't developed new symptoms. "This can be a quick call too, and it is a powerful way to reduce visits back to the ER, as well as readmissions."

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More proof that hospitalists save money

First study of large group shows reduced LOS and costs per case

The body of medical literature that indicates hospitalists are good for patients and the bottom line continues to grow. But there has been a weakness in some of the studies that have been conducted: they looked at relatively small hospitalist programs or didn't use concurrent control groups as a comparison. Now, a study that looks at a large number of hospitalists and a concurrent control group has eliminated that weakness. The results, published in the May issue of the *Journal of General Internal Medicine*, found that hospitalists have a lower length (LOS) of stay than other specialists, as well as lower total costs.[1]

The study looked at nearly 2,600 patients on the general medical service at the University of Michigan Hospital in Ann Arbor over the course of a year. The patients were assigned to

one of 40 attending physicians, seven of whom were defined as hospitalists. Other physicians included general internists, rheumatologists, nephrologists, endocrinologists, or part of another specialty. The researchers looked at length of stay, total costs per case, as well as patient outcomes such as 14- and 30-day readmission rates, and inpatient death rates. Hospitalists cared for just over 900 patients, and non-hospitalists cared for 1,639.

The results showed that patients who were cared for by hospitalists had a mean length of stay of 4.35 days, compared to 4.66 days for their non-hospitalist counterparts. The costs per case were $7323 for hospitalists compared to $7394 for non-hospitalists.

The results were strong, but might even have been more pronounced in favor of hospitalists if the hospitalist service in Ann Arbor had been more formalized, says lead author **Vikas Parekh**, MD, director of Non-Housestaff Hospitalist Services, Division of General Medicine at the University of Michigan in Ann Arbor.

"When people have focus or a goal in mind, they do a better job accomplishing it," he says. "I think that if we had an established program when we did this study and the physicians knew we would focus on length of stay and costs, they results might have been more robust still. But our physicians also had other outpatient duties, and there was less time to manage their patients as issues arose."

Proof helps formalize program

With the results from this study, the Ann Arbor hospitalist service became more formalized. It now has a core group of seven hospitalists who spend a minimum of one-quarter of their time as inpatient attending physicians. Another four spend about half their time on inpatient care, says Parekh.

Should they do this study over again in a year or two, Parekh says, the results might be even more positive, since one of the findings was that experience matters. "The more experience a hospitalist has, the better they do in terms of cost and utilization," he says.

One thing that Parekh couldn't replicate in his study that others have found is improved outcomes for hospitalist patients. "For us, inpatient death is such a rare outcome," he says. "We have a very low overall mortality rate throughout the institution as a whole, and the people who die don't do so on our service. They die in a closed intensive care unit. That makes it harder to track. It also might be that mortality just won't be an outcome that will improve with hospitalists."

As for longer term outcomes, like whether the hospitalists' patients do better a year or two after discharge than other patients, that will be something for researchers to look at in the future, Parekh says.

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The goal of the study was to look at several issues, including the role specialists are playing in the hospitalist movements.

"We aren't the only ones to look at this, but specialists are taking care of patients outside their realm of expertise, and what we found is that they may not do as well with as they do with patients whose care fits more in line with their experience," he says. "From a resource standpoint, that is a negative."

The other thing Parekh wanted to study was what happens in a broader larger system. "Many studies show gains, but the hospitalist services are so small you have to ask yourself is that just because of these particular physicians, or is it because they are hospitalists? We looked at a larger group of physicians who didn't necessarily think of themselves as hospitalists, but were still very experienced."

Beyond length of stay

Parekh says that eventually, hospitalists are going to have to move beyond what they can do in terms of resource and financial issues. "At some point, we aren't going to be able to show any more incremental gain," he says. "Length of stay will drop to some plateau level and then you're going to have to figure out what you can bring to an institution or hospital."

He says that he sees his role as a systems engineer. "We can dissect and improve some areas of the hospital system that have an impact on quality of care. Rather than trying to maneuver patients through the system, we can find a way to deliver better care."

Despite what he sees as the potential shift in the *raison d'etre* of hospitalists, Parekh says that there will continue to be a benefit from having hospitalists take care of hospitalized patients.

"This study shows that other physicians aren't always the best people to take care of their patients who are in the hospital. Unless we change how we hospitalize patients and who we hospitalize, we, as a specialty, will continue to have a beneficial impact on patient care," Parekh says.

Editor's Note: Contact Vikas Parekh at (734) 647-2892.

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What women (hospitalists) want: flexible scheduling, mentors, leadership opportunities

Last year at the Society of Hospital Medicine meeting, a group of women and men met to discuss what the key issues were facing women in hospital medicine. That men attended at all surprised and gratified **Preetha Basaviah**, MD, an assistant clinical professor in the department of medicine at University of California - San Francisco, and a hospitalist in practice at the university's medical center.

They came because they were in positions of leadership in hospitalist groups and knew that with the continued exponential growth in the specialty, women were going to have to be courted to meet the staffing needs of their groups. And if they were going to be courted, these men knew they had to be clear on what women hospitalists needed to be successful and happy in their jobs.

This year, there were no men among the 15 participants at the SHM forum on women in hospital medicine, says Basaviah. But the issues raised were the same. Women want and need flexible scheduling options. They need to have them particularly if they are pregnant or have small children or other family needs. They want to have time to nurture outside relationships. They don't want to be penalized professionally for being parents or family caretakers. They want career growth options and leadership positions. They wanted their concerns to be taken seriously.

Flexible work schedules

The women shared some of the innovative solutions they came up with to make sure that neither their work lives nor their home lives suffered and talked passionately about their experiences, says Basaviah.

Among the ideas shared were moving to a 75% or 80% work schedule. While some women worried that this would impact the way their superiors viewed them, Basaviah says a conversation with her boss made her feel a lot more comfortable about her own choice to move to an 80% work load.

"He told me that when he looked at everyone working, he couldn't tell who was 80% and who wasn't," she recalls. "He told me everyone was productive in their own way."

Those who work 80% -- and that doesn't necessarily mean you have a day off, but that you only spend 80% of your time on clinical duties, Basaviah explains -- or even 50% often make up for it by taking on administrative or committee responsibilities that others don't want. That allows them the flexibility to do some work from home or to make sure they get out of the office at a reasonable time to be with their families.

Another option is to have informal internal switches. Those with family responsibilities can find 14 or 21 day scheduling difficult, Basaviah says, so they may, within the service, decide to give each other a day off. "I'll work a day or two for one of my colleagues, and she'll do the same for me," she says. They don't involve the administration.

Informal arrangements to cover shifts should an emergency arise or a child or parent become ill also work well, she says.

Accommodating pregnancies, child rearing

Alerting administration to pregnancy as soon as possible can also help them schedule appropriately. "You don't want to be doing clinical rounds when you're nine months pregnant and have swollen ankles," she says. If you are breastfeeding and need to pump three times a day, you don't want to go back up on the wards right away either.

Women haven't always been good at asking for what they want and need, says Basaviah. But if they want to have flexible

scheduling options, they need to be firm in their requests and negotiations. "We aren't conditioned to do that," she says. "We fear the repercussions. But you don't know if you can get it unless you ask for it. Be concrete in your requests and you just may get the schedule you want."

Likewise women have to learn how to set limits. If you can't work night shifts, don't. But offer to take on some other duty that others find less palatable -- like committee work -- that doesn't interfere with your scheduling needs.

If you do get a schedule that allows you to have time with your family, make sure you use it for that, she says. "It can take discipline to stay true to your goals," she says. "The more senior women in the group said that if you choose Friday for your family, then use the time to go to the zoo or do something with your family. Don't spend that time catching up on work or chores."

The more women the better

Women looking for a new position would also do well to find a group that has at least one woman already in it, Basaviah says. That's not an issue in her group, which are more than half women. Of those who have children, only one works full time. The demographics of her group allows Basaviah to better network and talk openly about the issues facing women, whether they are pregnant, new moms, or have aging parents to care for.

One of Basaviah's colleagues is **Arpana R. Vidyarthi**, MD. Currently early in her first pregnancy, she says she has reaped the benefits of having a large number of female colleagues.

Another thing playing in her favor is that hospitalists are part of a new specialty that hasn't yet developed any culture, let alone one that is dominated by an old-boys network. "Some specialties really are male dominated and the culture of the specialty shows that," says Vidyarthi. That hasn't happened with hospital medicine.

"We don't have those hurdles, and that's a good thing," she says. If anything, the culture in her group is female centric. "There is this community of women who will come forward if a child is sick or the day care is closed. If I was looking for a position, I know that is something I would look for in a group."

Certainly as more women enter this specialty, that kind of care taking culture will likely become more common. "As a whole, I think there will be women in sufficient enough numbers that this won't become an old boys network. This is a specialty that is growing fast and a lot of women are coming in. The leaders in this specialty are going to have to listen to our needs. If they don't, we'll leave and form our own groups."

'As a whole, I think there will be women in sufficient enough numbers that this won't become an old boys network. This is a specialty that is growing fast and a lot of women are coming in. The leaders in this specialty are going to have to listen to our needs. If they don't, we'll leave and form our own groups.'

Arpana R. Vidyarthi, MD

Not just for women

Calling these women's issues is perhaps a bit misleading, says Basaviah, and implies a set of political baggage. "They are family issues. They deal with children and the elderly and our homes. It is constructive for hospitalist groups and the profession as a whole to deal with this."

The benefits include a happier and more productive workforce, Basaviah says. "Inflexible schedules can cause people to leave their jobs," she says. One woman at the forum told the story of her run in with her bosses. She has a child with special needs who often had multiple doctors appointments "They were quite insensitive to it, asking why she couldn't deal with it all on her one administrative day."

Along with psychological burnout and unhappiness, there can be physical repercussions, too. An inflexible schedule for a pregnant hospitalist can lead to bed rest and hospitalization. Again, says Basaviah, we are back to lost productivity.

It will be interesting, she says, to see who shows up at the forum at next year's SHM meeting. In the meantime, one or more of this year's participants may set up a section on the SHM web site for family resources and support.

Editor's Note: Contact Preetha Basaviah at (415) 514-2095/2094 and Arpana R Vidyarthi at (415) 514-0887. ☑

10 traits every coordinator needs

Hospitalist service managers spell out what it takes to keep programs humming

Whether you are looking to expand your program or are just starting one, having the right person in the seat as program coordinator or service manager is vital. Recent discussions on listservs have shown just how hot the topic of a good coordinator is. Indeed before the recent Society of Hospital Medicine meeting in New Orleans, more than a dozen people sought sample job descriptions. Many of the coordinators met at the conclave for an informal chat.

What does it take to sit in that seat? Three nurse coordinators at different points in their careers with a hospitalist service talked about the kind of person they would look for if they were seeking a replacement for themselves. Here's their top 10 list.

> 'You have to have good people skills. You are the liaison between the physicians and other team members and must have credibility with all sides. Every member of the hospitalist team needs to know that you understand their world.'
>
> Sandra C. Folkenson, RN
> Hospitalist and Intensivist Program Coordinator
> St. Joseph's Hospital
> St. Paul, MN

1. Find an honest broker. In the olden days, this would fall under the heading of "good communication skills." But it isn't just about being able to write a clear sentence, or even to be able to speak well, says **Sandra C. Folkenson**, RN, the hospitalist and intensivist program coordinator at St. Joseph's Hospital in St. Paul, MN. "You have to have good people skills," she says. "You are the liaison between the physicians and other team members and must have credibility with all sides. Every member of the hospitalist team needs to know that you understand their world."

2. Firefighting experience a must. Folkenson and her peers spend much of their days putting out fires and dealing with problems, many of them seemingly intractable. "There's always some situation. I get most of my calls about things that aren't going well that aren't flowing. I have to be able to quickly gather data, negotiate, and resolve issues."

Avoiding the black hole

For example, she explains, a physician will write an order to tag a specific service and that service will say they never got the tag. "I get an angry call saying 'No one told us.'" It becomes a he said/she said issue. Folkenson calls it "the black hole" where she is sent to solve age-old problems that no one could solve before.

With the tagging issues, she started by gathering information from the answering service and clinic coordinators about how the process is supposed to work. She visited with nurses and unit coordinators and asked how they processed orders. Folkenson says that her experience at the hospital as a clinical educator and nursing supervisor helped her to get good information from all parties: they knew and trusted her. "They don't see me as trying to lay the blame anywhere."

3. Diplomatic experience required. Folkenson's diverse professional background, which brought her into contact with many different team members, helps her keep in mind that everyone needs their own professional autonomy. "You can never allow any one team member's professional agenda to take over," she says. While her nursing background means she is a fierce advocate for the nurses, she never allows that to color doing what is best for the service. "You have to allow each person to do what they are good at."

4. Seek a multi-tasker. Every job description says it: strong organizational skills required. But Folkenson says that particularly for people who are just starting a program as she is, someone has to be able to manage multiple tasks and projects, prioritize jobs, and think critically about decisions and how they will affect not just the service, but people who work with and around the service, too.

Right now, for instance, Folkenson is in the midst of recruiting new physicians. She did the prescreening of all the candidates, set up a panel of physician interviewers to take them through the final interview stages, and is planning a reception with the administration, the clinic they are hired into, and the candidates.

"I have to bring them into a room together before they accept to see if they can stand each

other and work together." What she has to keep constantly in mind is that these new physicians will be connected to a clinic. "I'm a hospital employee and I'm hiring folks who will be involved with a whole group of established physicians in an organization outside my own. I can't just think about how they will work in our service. I have to think beyond that."

5. Broad experience, please. Most program coordinators will have at least some responsibilities for areas that are outside clinical and nursing skill sets such as marketing. Folkenson is in charge of marketing the hospitalist program to physician clinics in the hospital's health system, to physicians outside the system who have admitting privileges, and to hospital nursing staff. She also has to create information for patients.

As far as clinical expertise, Folkenson says well balanced experience is vital. "You don't have to have an ICU nurse capable of treating CABG patients. But you need some solid acute care experience that allows the person to triage acute care issues.

Strong medical/surgical background is key

Most hospitalists are internal medicine trained, says **Mikkii Swanson**, RN, CMC, manager of the inpatient case coordination and hospitalist service at Carle Foundation Hospital in Urbana, IL. "I think having a medical/surgical background is important because it meshes with the experience our physicians have."

That said, Swanson herself comes from a home care background. She says that helps her because she has been required to make clinical decisions without someone in the next room.

Whatever the clinical background, Swanson thinks that more of it is better. "I don't think someone who is just two years out of nursing school could do a great job in this role," she says. "You have to understand a bit about practicing medicine. You have to understand diagnostic tests, lab results, medications,

A day in the life of a hospitalist nurse coordinator

So just what does a nurse coordinator do all day? *Hospitalist & Inpatient Management Report* asked three coordinators to describe what -- aside from an interview with a journalist -- was on their platter on a specific day. Here are their answers.

Sandra C. Folkenson, RN, the hospitalist and intensivist program coordinator at St. Joseph's Hospital in St. Paul started her day with a chat with the hospitalists on service. She found out what the patient load was and acted as a triage person for the nursing staff and for the physicians. "I decide who needs to be seen first and help them manage their patients."

She tries to round with the physicians and meet with families every day, but while that was what the service envisioned her role to be, it has evolved over time. "I spend a lot of time troubleshooting, supporting physicians and helping them with coding issues and setting up the schedule," Folkenson says.

When she talked to *Hospitalist & Inpatient Management*, she was working on a physician orientation program for the new hires, as well as working on marketing projects. "I really try to make a point to round with the physicians and keep in tune with what is happening. I want to be visible. But right now, we're at a point in our program where I can't always manage that."

A more mature program means a different kind of day for **Mikkii Swanson**, RN, CMC, manager and inpatient case coordinator for the hospitalist service at Carle Foundation Hospital in Urbana, IL. Her service has been around since 1996 and as of July 1 will have 10 physicians, including the medical director.

A fairly typical morning: "I started my day by seeing what the census was, what the patients' diagnoses were, where they are located in the hospital, and where the hospitalists need to be," says Swanson. At 9:30 each morning, there is a multidisciplinary team meeting where the care plan for each patient is discussed, as are discharge needs and goals for the patients. Hospitalists, dieticians, nurse managers from the medicine and step-down units, case managers, social workers, the hospital chaplain, a pharmacist, and any residents on the service attend that meeting, which typically lasts about 45 minutes.

Most of the rest of her day is spent triaging between hospitalists and the case management group. "This morning we had a case where we had to do a payer review," she says. "I tracked down charts and labs. I talked to the physician about moving the patient, when we were expecting that patient to go for diagnostic tests. Then when we knew where we were, I went to the family to discuss it with them."

On some days, she'll do chart reviews to see if clinical practices matches the program's

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and what it all means to the patient. If I was trying to build a program, I'd want someone with a lot of nursing experience behind them, and some level of supervisory experience included in that."

6. Autocrats need not apply. While confidence and the ability to command respect are important, Folkenson says anyone with a controlling personality who can't "flex and roll" with different situations won't survive the job. "When things don't work, the best question is how can we make it work and what do we need to do to make something happen. You can't just give an order." Crusty, unmotivated, unenthusiastic people are also bad fits for the job, she adds.

7. Good leadership skills needed. Folkenson emphasizes that nurse coordinators have to be able to command the respect of a multidisciplinary team and have the self confidence to stand up and say when something isn't right.

Swanson adds that the role is kind of like a counterpart to the medical director, and a good nurse coordinator will be able to step in when the medical director is gone and communicate on a peer to peer level with the hospitalists on the service. Much of what she does is dealing with problems so that the medical director doesn't have to.

"Whether it is a physician, a patient, or a nurse that has the problem, I have to stand up and deal with it unless I truly believe the medical director needs to know," she says. "You have to have critical thinking skills, but those skills must also be trusted by the physicians."

Ask the right questions

8. Can you think critically? You have to have the skills to ask critical questions about a particular patient." As a nursing supervisor, Folkenson says she was often asked to come

A day in the life of a hospitalist nurse coordinator (continued)

design -- whether particular diagnoses are automatically coming into the service and whether standing orders are being carried out. Other days, she might go out and do site visits to top referring physicians in the community and give updates of the program, explain changes, and address any concerns they have.

Visiting the floors on most days

Most days, Swanson manages to get up onto the floors. But some days are too busy. She says that because she does both case management and hospitalist work, she spends about 10 hours a day at work. But if her role was solely with the hospitalist service, Swanson says she'd spend about eight or nine hours a day at it.

Like Folkenson, the hospitalist program at Sioux Valley Hospital in Sioux Falls, SD is relatively new -- just 15 months old. But the job that **Heather Herlyn**, RN does as coordinator of the service is different than what either Folkenson or Swanson does, having much more of an administrative flavor than her peers.

On a given morning, she'll come in and print the patient list for the day and review what happened over night. She tells the nursing staff what two physicians are on the service and how to contact them.

At the time of her conversation with *Hospitalist & Inpatient Management*, she was in the process of recruiting, so she was spending a lot of time working on credentialing and creating an orientation manual. She spends time each day on billing and ensuring that monthly financials are up to date. She'll also do tracking of quality data such as length of stay, costs, and DRGs.

No time for rounds in a new program

What she doesn't do is rounds. "When we started, we had a dedicated case manager who did that, but the floor managers wanted to be more involved, so now they do that." But Herlyn says visibility is important. She tries to make sure she takes time to walk around and ensure that any problems that existed yesterday have been solved to the satisfaction of all parties today. Still, she misses that patient contact. "I get the story of the patient, but not directly. I just see the notes and hear the stories," Herlyn says.

Lastly, she spends time doing marketing work, ensuring that the people who need to know about the hospitalist service do, and that those who use it are happy with it.

Over time, Herlyn says, she sees her role changing further. "I'd guess that within a year we'll have at least eight physicians and my role will continue to be more and more managerial -- something akin to a clinic manager. There will be someone else doing all the leg work I do now and I'll get more involved in business development."

look at a patient who "didn't look right." She'd go up and ask pertinent questions. She didn't always have the answers, but her questions could help the team focus their energy and ideas to solve the problem.

"It's one thing to read a chart and figure out what you are doing the next day with a single patient," says Swanson. "It is another thing to look at several patients and put it all together in a way that defines what your hospitalist practice is going to be."

'It's one thing to read a chart and figure out what you are doing the next day with a single patient. It is another thing to look at several patients and put it all together in a way that defines what your hospitalist practice is going to be.'

Mikkii Swanson, RN, CMC
Manager
Inpatient Case Coordination and Hospitalist Service
Carle Foundation Hospital
Urbana, IL

9. Be number savvy. Heather Herlyn, RN, the coordinator for the hospitalist service at Sioux Valley Hospital in Sioux Falls, SD, says no one who is nervous around numbers could do a good job in her role. "You have to be comfortable and competent in preparing statistical and analytical reports. And you have to be able to present the information in a way that is appropriate for the particular audience you are addressing." That means what you put together for your hospital's administration may have different characteristics that what you prepare for your physicians and for patients.

10. Did we mention good communication skills? It bears repeating, says Herlyn. A huge amount of her time is spent talking to different stakeholders and running interference between various parties. She has to be able to speak confidently to and be the mediator between hospitalists and the other hospitalist staff, hospitalists and their patients, nurses and the ancillary staff, and the hospital administration. And if she isn't talking to them, she is writing reports for them or about them.

Between the three nurse coordinators, one overarching message is that their jobs are varied -- as varied as the hospitalist practices they work for. There is no task they won't undertake, from answering phones and clerical work to doing patient satisfaction surveys and quality improvement reports. They triage patients and are probably more familiar than anyone on the service with what is happening with all the patients on the service. And they provide a link between hospitalists and every other person, department, and outside organization that deals with the service.

Editor's Note: Contact Sandra C. Folkenson at (651) 232-3548, Mikkii Swanson at (217) 326-2586, and Heather Herlyn at (605) 333-5588. ☑

NEWS BRIEFS

Cogent signs with St. Francis Healthcare

Cogent has added another health system to its client list, signing with Roper ST. Francis Healthcare of Charleston, SC, in May. Cogent will develop an inpatient management program and provide hospitalist services for the three-hospital system.

"Hospitalist programs are becoming a popular and highly effective way to improve the quality and efficiency of the care that hospitalized patients receive," says **Don Pocock**, MD, vice president of Medical Affairs for Roper St. Francis Healthcare.

IPC gains Missouri client

Parkland Health Center in Farmington, MO, has chosen IPC to provide a broad range of inpatient services at the 130-bed facility.

These services include coverage for all unassigned patients in the emergency department, medical management for geropsychiatric patients, and consultations for sub-specialists along with inpatient management for patients of referring physicians. IPC already provides hospitalist programs at three other hospitals owned by Parkland's parent company, BJC HealthCare.

The first physician hired for the Parkland

Health Center program was **Shivaramaiah Shashikumar**, MD, an internist who has been in private practice in the Farmington area for about a year.

Meanwhile, late in April, IPC announced an agreement to provide hospitalist services for two hospitals that are part of Vista Health in Waukegan, IL, Victory Hospital and St. Therese Medical Center.

"We entered into this agreement with IPC because of their outstanding track record of providing quality patient care in an efficient and patient-sensitive manner," says Vista Health's chief executive officer **Tim Harrington**.

"Their presence will help enhance the care we provide to our patients, including many who come in through the emergency department, and allow us to better manage our own internal resources." Hospitalists Heberto Hernandez, MD, and Azmina Bhaiji, MD, are working at the facilities already. Additional physicians are awaiting privileges at the two hospitals. This brings to nearly 30 the number of IPC physicians working as hospitalists in the Chicago area. According to the company, last year these doctors had more than 53,500 patient encounters.

QI tools available on the web

Interested in seeing protocols, pathways, and quality improvement tools that other hospitalists use? Do you have a tool that you think others might find useful? The Society of Hospital Medicine's HQPS Committee is developing a web-based repository of such tools.

Available through the SHM website, users can find it by going to www.hospitalmedicine.org and clicking on the HQPS area listed on the left hand side of the web page. There's a section for QI improvement tools there. Those wishing to submit a tool can download the QI submission cover sheet, complete it, and send the tool and sheet as a word or PDF file to halasyal@trinity-health.org.

Tools will be on the website for at least three months.

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Hospitalists improve end-of-life care for patients

Hospitalists who care for the dying are better at providing comfort care than their non-hospitalist counterparts, according to a study published in the May 15 issue of the *American Journal of Medicine*.[1]

While both groups of physicians prescribed long acting pain medications for their patients, those who were cared for by hospitalists were more likely to report no symptoms in the 48 hours before death.

According to the authors, better communication with dying patients and their families may have been the reason behind perceptions of better end-of-life care.

Reference

Auerbach AD, Pantilat SZ. End-of-life care in a voluntary hospitalist model: effects on communication, processes of care, and patient symptoms. *Am J Med* 2004 May 15;116(10):669-75.

Society of Hospital Medicine to meet on West Coast

The West Coast Regional meeting of the Society of Hospital (SHM) medicine won't happen until the end of September. But if you register by July 30 you can take advantage of a $150 discount and pay only $500 for the three-day event.

Among the topics on the agenda: perioperative care of the geriatric patient; a pain management workshop; issues for academic hospitalist practices; and survival skills for young hospitalists.

More information is available at http://medicine.ucsf.edu/cme/2004cal/M05458.html or by calling (415) 476-5208.

Meanwhile, the Southern Regional meeting of the SHM will feature a management precourse at its November meeting. It will include topics such as recruiting, managing, and expanding hospitalist programs. The meeting itself will include workshops and lectures on a trial fibrillation, heparin induced thrombocytopenia, resuscitation, neurological problems, and coronary syndromes.

Held in mid-November in Orlando, FL, more information is available at the SHM website, www.hospitalmedicine.org. ☑

New APC coding and OPPS reimbursement resource just released

NHI has just released a new resource that medical records and coding professional won't want to miss. *48 Key Strategies to Improve APC Coding and Maximize OPPS Reimbursement* is a comprehensive collection of best APC coding practices -- complete with case study examples designed to enhance compliance and boost your facility's OPPS reimbursement.

Produced by the publishers of *APC Advisor* and reviewed by an industry-leading coding expert, *48 Key Strategies to Improve APC Coding and Maximize OPPS Reimbursement* pulls together strategies in the most-used categories as well as the most challenging aspects of APC-related coding.

The strategies are fully indexed and divided into 38 categories for quick reference. Topics addressed include cath labs, diabetic neuropathy, E/M codes, emergency department, infusion therapy, observation services, psychological interventions, supplies, white coat hypertension, and much more!

To order your copy of *48 Key Strategies to Improve APC Coding and Maximize OPPS Reimbursement* for only $99 plus $5.95 shipping and handling, call 1-800-597-6300 with your credit card information or fax to 404-607-0095. You may also send your payment and shipping instructions to NHI, PO Box 15429, Atlanta, GA 30333-0429. You may also order online at http://www.nhionline.net/products/apcbook.html. ☑

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