The Role of Hospitalists in Healthcare

By

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The Role of Hospitalists in Healthcare

Abstract

The hospitalist model, first implemented in 1996, is a new specialization created to help the PCP reduce time spent in hospital visitation by 30% to 40% along with length of stay and inpatient costs. In this presentation we examine whether the use of hospitalists has improved the quality of inpatient care in hospitals where the model has been implemented. To explore this hypothesis, literature review along with a series of interviews were conducted with Cooper University Hospital (CUH) and Camden Coalition (CC) staff members- 3 Social Workers, 3 Nurses, 2 Physicians, 1 Nurse Practitioner and 1 Hospitalist. The aim was to assess whether the hospitalist model has improved the inpatient care at CUH. All ten persons interviewed reported that hospitalists serve as navigators throughout the hospital stay. Nine persons interviewed see the hospitalists addressing the needs of their patients effectively while one person concluded the opposite. Nine persons interviewed stated that hospitalists are effective in providing immediate acute inpatient care. Graphs were then developed through the NVivo9 software by coding all of the interviewer’s perception regarding quality and financial terms. The end result is that the hospitalist model is beneficial and effective in a hospital setting. Future studies should continue to examine the evolving hospitalist role related to inpatient safety, quality and cost-effectiveness.
Background

Historically, primary care physicians (PCPs) in the United States have cared for their patients in both ambulatory settings and hospitals. However, in 1996 the hospitalist movement began to be stimulated by two primary concerns. These concerns dealt with inpatient costs and lengths of stay.¹ Other concerns that eventually brought this movement forward as well were the time pressures brought on PCPs to visit their patients on a daily basis and the increasingly complex inpatient medical care.²

Hospitalists are physicians who specialize in the practice of hospital medicine. They receive the same amount of training as any physician. Following medical school, hospitalists typically undergo residency training.³ They spend the majority of their professional time practicing in the hospital, and in this respect are similar to emergency medicine or critical care specialists. Furthermore, hospitalists are no different than physicians and non-physician providers regarding engaging in clinical care, teaching, research, or leadership in the field of general hospital medicine. In addition to their expertise in managing the clinical problems of acutely ill, hospitalized patients, hospitalists work to enhance the performance of hospitalists and healthcare systems.³

Traditional models of the healthcare delivery in the United States place the admitting PCP as the physician of record for most non-surgical hospitalized patients, with assistance as well from specialists. In the hospitalist model the PCP transfers the responsibility for hospital care to a hospitalist, whose expertise is defined not by an organ system but by site of practice. The use of hospitalists in this aspect represents a dramatic break with tradition. The hospitalist then refers these patients back to their PCP at the
time of discharge. The hospitalist model has received widespread acceptance in the USA by expanding from academic medical centers to community hospitals. The first academic hospitalists simply replaced general internists and subspecialists as attending physicians on general medical ward teams.11

The need for hospitalists was first encountered in the Park Nicollet Clinic, a large, multispecialty medical group located in Minneapolis-St. Paul, Minnesota.4 Since then the hospitalist model has seen a growth in the United States and ultimately became a significant, if not the, dominant, model for inpatient care. From the time the hospitalist model was established in 1996 to 1999, 65% of internists or PCPs had hospitalists in their community and 28% of them reported using them for inpatient care.5 As of 2008 there were 20,000 practicing hospitalists with a potential of reaching 40-50,000, which eventually will surpass cardiology in size.6 This represents a significant increase from 5,000 hospitalists in 2002. Furthermore, 80% of these hospitalists were known as internists.

As of 2009 The Society of Hospital Medicine states that the locations of hospital medicine groups where hospitalists practice are broken down by region. These regions are as follows: the eastern of the United States has the highest usage of hospitalists at 31%, the western coast has the lowest at 21%, the south had a 28% while the Midwest had 20%.7 A study done by Pham et al. in 2004 looked at the factors affecting hospitalist use and practice models in three communities.8 These communities are Orange County (CA), Phoenix (AZ) and Miami (FL). Orange County saw a rise in hospitalists use because of the need to control cost among both health plans and medical groups and the desire of their medical staffs’ for more outpatient care time under reimbursement
Pressures. In Phoenix the rise of hospitalists was attributed to a shortage of physicians due to them having interests in other sources of revenue besides inpatient care. In Miami the increase of hospitalists was due to physicians’ focus on increasing outpatient visit volume along with a malpractice insurance crisis leading physicians to avoid inpatient care and the lack of hospital beds.

Another study done by Wilson in 2008 looked at the Canadian healthcare system and why hospitalists arose. The rise of hospitalists was contributed to by the diminishing of community family doctors along with the difficulty for them to squeeze hospital rounds into their expanding workdays. For the most part these community family physicians quietly welcomed being excused from this aspect of the job once hospitalists were hired. It is estimated that American primary care physicians since the rise of hospitalists in 2002 now spend an average of 12% of their time in the hospital.9 In a study done by Sanchez et al. in Philadelphia at the University of Pennsylvania attributed the use of hospitalists to the shortage of general surgeons.10

An article by Srivastava et al. “Community and Hospital-Based Physicians’ Attitudes Regarding Pediatric Hospitalist Systems” conducted a study of the attitudes of both the community and hospital-based physicians in order to identify both the positive and negative with having a hospitalist system.11 Responses to the questionnaire showed that community physicians were less likely than hospital-based physicians to think that there would be an increase of patient satisfaction and improve quality care. These community physicians, however, were more likely than the hospital-based physicians to suggest that care of inpatients was better left to the physician who maintained a long-term relationship with the patient.
All twenty five of the articles in the literature researched suggest that the rise of hospitalists evolved because of inpatient costs and lengths of stay. One article further suggests that the rise of hospitalists was because of the increased acuity of the hospitalized patients and the accelerated pace of their hospitalizations. Another article suggests the cost pressures on health plans. Another article hints toward another reason as well. This reason is for the simple fact that PCPs try to avoid time-intensive travel and greater care burdens of inpatient care to maximize outpatient visit volume. Overall, all these twenty five articles have in one way or another confirmed that all these drivers remain prominent and further revealed that the hospitalists use has become more integrated with hospitals’ competitive strategies. As a result of these immediate interventions an article by Pham et al. further suggests that the hospitalist model improves the quality of care of specialty and surgical patients which in turn makes it easier for policymakers to put on their agenda when improving the healthcare system along with seeking to improve the quality of care that are given to patients. Another result of these interventions has also lead an article suggest that patients are more willing now to trade familiarity for the availability of the hospitalists.

Another article “Do Hospitalist physicians improve the quality of inpatient care delivery? A systematic review of process, efficiency and outcome measures” by authors White and Glazier suggest that as a result of the hospitalist movement the on-site availability of a hospitalist ensures that a dedicated provider is readily available to answer questions, order along with manage tests while also responding during any medical crises. As a result of hospitalists also seeing so many diverse patients with many different ailments the article further suggests that hospitalists could potentially enhance
their clinical expertise, thus leaving the PCP or other specialty behind medical interventions. This ultimately could translate to having better patient outcomes in comparison to PCPs who manage fewer cases of a given condition over the same period of time.

On the other hand all twenty five of these articles in the literature researched also suggest that hospitalists are an added burden as well as a benefit to the healthcare system. An article by Pham et al. suggests that implementing the hospitalist model in the healthcare system coordination becomes more complex for the patient by simply increasing the number of providers and organizations involved in the hand-offs of patients. The author further states that this further complex looks at where the hospitalist affiliation or interest lies. These affiliations could lie with the hospital, a health plan or other sponsors. Authors Ruth et al. in their article “Evaluating Communication Between Pediatric Primary Care Physicians and Hospitalists” also suggest that having hospitalists accept patients from their PCPs at the time of admission to the time of discharge may produce variable levels of discontinuity in care which could potentially raise a concern when it comes to increased patient morbidity. They further state that a particular concern is the poor communication to relay appropriate information regarding their patients to the PCPs regarding discharge and pending laboratory tests which could ultimately translate to the patient being readmitted for care. The authors in the article suggest in order to correct such a dilemma communication between hospitalists and PCPs must be consistent along with timely and informative as suggested by the American Academy of Pediatrics (AAP).
As the healthcare costs increase so too has the evolution of the role of hospitalists since 1996. One article suggests that 68% hospitalists now participate in quality improvement initiatives. On top of that another article suggests that 59% of the hospitalists play a part in formal utilization review, and 54% are also involved in hospital electronic medical records and computer provider order entry initiatives. Hospitalists are also currently involved in improving their patient handoffs by partnering with outpatient providers especially in the care of complex medical patients. They are also involved in developing hospital-based services such as palliative care and rapid response teams. In the same way, hospitalists’ clinical roles have also changed drastically.

Overall, for much of medical history, hospitals were seen as places where patients came to get better; however, over the past decade medicine has seen the development of numerous specialties such as hospitalists whose expertise may be defined by the procedures they perform, the type of patients they see, or the location in which they practice. This has been characterized by their distinctive training programs and evidence that focused training and practice yields better outcomes. As the medical healthcare system continues its evolution away from the general practitioner to a plethora of specialists, hospitalists are just the latest in a series of improvements. It is safe to say that the next decade is likely to be marked by the continued expansion of the hospitalist model and by the continuous efforts to achieve its manifest benefits while simultaneously developing better approaches to address its potential shortcomings.

**Problem Statement**
Despite more than a decade of research on hospitalists and their performance, disagreement still exists regarding whether and how hospital-based physicians improve the quality of inpatient care delivery. One body of research suggests that the hospitalist enters with no firsthand knowledge of a patient’s medical history. As a result, he or she may be inclined toward more aggressive, technology-based care, which could translate to the use of more diagnostic tests and higher costs to establish the baseline health status of the patient. Other research suggests that the hospitalist model may reduce lengths-of-stay, improve quality of care for specific conditions, and lower hospital costs.

**Hypothesis**

Due to increasing cost in healthcare, as well as the cost of hospital stays, hospitals began to use the hospitalist model for the care of inpatients. In this project, we will consider research and interviews regarding hospitalists as an innovation in an effort to weigh the benefits of the hospitalist model against possible problems it may generate. On the basis of published research and data collected from interviews for this project, I will test the following hypothesis: the use of hospitalists has improved the quality of inpatient care in hospitals where the model has been implemented.

**Research Goals**

At the beginning of the 2011 Fall Quarter for my Community Based Master’s Project (CBMP), I conducted literature research on hospitalists and the hospitalist model along with their role in the hospitals. Along with the research, I created a questionnaire
for interviewing individuals in the healthcare field, such as physicians, hospital staff, and
hospitalists, to assess various perspectives on the effectiveness of the hospitalist model.
The interviews were manually transcribed and general themes throughout the ten
interviews were gathered throughout the whole Fall Quarter and allocated and discussed
appropriately within both the “Research Finding” and “Discussion of Findings.”
Furthermore, the interviews were analyzed using the NVivo9 software to discern the
most common themes or topics discussed by all the interviewers. The actual interview
process and collection of data at Cooper University Hospital in Camden, New Jersey, began
on January 9, 2012. At the end of the oral defense and final report of May, 2012, I tested the
hypothesis and gave outcomes on the basis of the research. These outcomes are as follows:
develop an analysis of how, and to what extent, the hospitalist system is employed in
Camden, develop recommendations for improved communications between hospitalists and
PCPs, and develop an analysis of the cost effectiveness of the hospitalist model. The last of
three outcomes originally proposed was not further pursued because of lack of data or
information readily available in both the literature and interview process. Instead,
considering the fact that the hospitalist model was implemented for financial reasons, I still
reserved a separate theme for “financial” to be discussed, considered and analyzed. I will
further discuss themes relating to patient care and patient communication under “quality.”

**Methods**

**A. Data Collection:**

The following section will discuss a form of considering and analyzing the quality of care
that the hospitalist provides along with evaluating the role of the hospitalist in a hospital
setting. The data collection will target Cooper University Hospital, in how they use the hospitalist model. A questionnaire and literature review along with the NVivo9 software will be the methods used to help access my outcomes previously discussed.

1.) Literature Review
- Identify the causes for creating the role of hospitalists and how it has evolved.
- Identify challenges and benefits of having hospitalists in the healthcare industry.
- Evaluate the findings from published research regarding cost, benefits and/or deficits incurred through the hospitalist system.

2.) Questionnaire
- Identify perceptions of physicians, hospital staff, and health insurance company representatives about the role of hospitalists and what it should be.
- Identify if the hospitalist model has shown to be a challenge or a benefit to the healthcare industry. If so, what are these challenges or benefits composed of.
- Determine scope of responsibilities for the hospitalists and how they address the needs of their inpatients.
- Assess the amount of communication between hospitalists and PCP’s.
- Identify challenges and benefits of the current communication between hospitalists and PCP’s.
- Identify areas of responsibility that appear to be best served by hospitalists as well as areas in which they are less effective.
- Examine differences in how hospitalists carry out their duties in the Camden hospital systems.
- Identify potential areas for increased communication and collaboration.

3.) NVivo9 software
- Identify common themes throughout the interviews by coding.
- Develop bar graphs to illustrate individually each interviewer’s perspective according to the themes identified (manually) and coded (Quality and Financial).

**B. Data Analysis:**

This section will discuss how the data was analyzed for the most common terms or themes mentioned throughout the interviews. The interviews were manually transcribed and then examined for current themes or topics within all the questions. Furthermore, the software NVivo9 was then used to transcribe the interviews as well to gather similar data collection in terms of themes or terms. Data collection was then taken and appropriate graphs were developed using the NVivo9 software. The use of common terms will fall under two main themes. These two themes will be titled “Quality terms” and “Financial terms.” Within these two subheadings one can find the most common terms that the entire interviewers’ shared throughout the whole process of the project. The purpose of gathering data through NVivo9 software is to provide another venue of collecting data through the use of technology along with providing a hand written transcription of these terms or themes.

**Limitations of Study**

Although this project will offer distinct outcomes, I acknowledge the fact that I will be limited with only three months of research. At the same time, this study will require that I interview four groups of five healthcare providers totaling twenty individual interviews within the Philadelphia and Camden health systems. Another limitation might be that not all of the interviews will be of hospital folks necessarily. Any study or research requires more than three months of research data to make an adequate conclusion. Depending on my schedule as well as theirs, I might not fulfill my actual quota of interviewing all twenty of these healthcare providers. Another limitation is that
there was no research on the cost-effectiveness that the hospitalists contribute to the hospital setting.

Another limitation that may arise is the fact that I may not be able to conclude with certainty whether my hypothesis that hospitalists and the hospitalist model are an effective specialty in the United States or for that matter in the Philadelphia and Camden hospitals. The next limitation that we have to take into account with the research is that I am only looking at the Philadelphia and Camden hospitals, not hospitals in the whole state of Pennsylvania and New Jersey. While these three hospitals serve as an indication, we cannot draw reliable conclusions regarding the general usage of the hospitalist model nationwide from such a small sample. Although initially this study was planned to include Philadelphia hospitals, the end result of this study was conducted in Cooper University Hospital in Camden, New Jersey.

**Research Findings**

Beginning January 9, 2012, of the Winter Quarter, my data collection of interviews will take place. The research findings will consist of three areas of concern. The first subheading of the findings will be “Interview Analysis.” Under this subheading, we will further breakdown all the interviewee’s responses to the questions by identifying common themes or responses regarding the role of hospitalists in healthcare that appeared most often. These themes or responses will be transcribed manually. The second subheading will be “Literature Analysis.” This subheading will contain results or findings of healthcare professional’s views regarding the role of hospitalists in healthcare through the use of literature. The last subheading will be titled “NVivo9 Software
Analysis”. This subheading will breakdown the most common terms mentioned during the whole interviewing process by coding them under the two themes “quality” and “financial.” As a side note, please see both Appendix A for a layout of the questions asked during this project and Appendix B where one will encounter a series of interviews conducted from Cooper University Hospital and Camden Coalition Healthcare Providers staff. These individuals include physicians, nurses and hospitalists. All their answers to the questions asked during the interview will be recorded and documented under these two appendices. Furthermore, Appendix C will illustrate bar graphs on the individual’s perception regarding quality and finances.

Interview Analysis:

The total staff members interviewed consists of ten individuals. Out of these ten interviewees, three were social workers, two primary care physicians, four nurse practitioner/nurses, and one hospitalist. Throughout the interview process, all ten interviewees shared a common theme that the hospitalists are in charge of inpatient care and serve as navigators. Another theme noticed in their response was the fact the roles of the hospitalists may have changed over time. Four interviewees said “yes” in regard to the roles of the hospitalist changing over time while two said “no.” The remaining four said “I’m not sure.” The next theme observed in the responses was that all ten interviewees saw a potential of more hospitals using the hospitalists model in the near future.

Another theme detected through all the responses was the interviewees’ perception that they see a financial reason, such as employment and benefits among others, as a driver for the roles of hospitalists to change in the future. The other theme
discerned through the responses dealt with the way hospitalists address the needs of their patients and outcomes. Nine interviewees see the hospitalists addressing the needs of their patients effectively while one does not. In terms of the outcomes, nine interviewees see the hospitalists being effective. The remaining interviewee did not respond.

The next theme revolved around the advantages and disadvantages of having the hospitalist model over the traditional model. In terms of comparisons between advantages and disadvantages of having the hospitalist model over the traditional model, two interviewees mentioned two advantages and disadvantages. Two other interviewees mentioned three advantages over two disadvantages. One interviewee mentioned four advantages over one disadvantage. The last five interviewees mentioned three disadvantages over two advantages in terms of having a hospitalist model over a traditional healthcare model.

The next apparent theme found within the interviews dealt with the communication between a hospitalist and a primary care physician (PCP). According to the interviewees, three said that communication is “not enough” while one said there is a lot. Another interviewee said “none” while the remaining interviewees said “it depends.” Another theme that appeared throughout the interview dealt with advantages and disadvantages of the current communication system between hospitalists and PCP’s. One interviewee mentioned two advantages and disadvantages. Another interviewee mentioned two disadvantages over one advantage. Another interviewee stated four disadvantages over one advantage while another interviewee mentioned three disadvantages and no advantages. Of the remaining two interviewees, one acknowledged no advantages and one disadvantage while the last interviewee did not answer at all.
The next theme that was apparent within the scope of the interviewees concern was: which areas of responsibility do they see hospitalists serving best at in their hospital as well as areas in which they are less effective. The majority of the responses in terms of which areas of responsibility are hospitalists serving best are: knowing the hospital system, being a navigator, decreasing length of stay and handling all immediate basic medical issues. On the other side, the interviewee’s said that the hospitalists are less effective when it comes to communication, trying to take care of other specialist issues such as cardiology, and looking at the whole patient as compared to just the problem.

The last theme that the interviewees dealt with was whether they thought a hospitalist in their hospital has proven to be cost-effective. Their responses were unanimously all “yes.”

Next, based on the literature research and interviews conducted which were then manually transcribed, I am providing two subheadings titled “quality” and “financial” to illustrate the most common terms that appear frequently within these two themes. It is important to understand the reasoning behind the selection of these terms under these two themes, which is because the hospitalist model ideally was implemented for inpatient care purposes (quality) along with decreasing the length of stay purposes (financial).

The following table will breakdown my viewpoint of what constitutes “quality terms” in relation to the role of the hospitalist as discussed in the literature review and interviews as well as how many times these terms appeared throughout the whole interviewing process.

- **Quality terms:**
<table>
<thead>
<tr>
<th>QUALITY TERM/S</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows patient</td>
<td>1 time</td>
</tr>
<tr>
<td>Patient needs</td>
<td>4 times</td>
</tr>
<tr>
<td>Change/same (role)</td>
<td>23 times</td>
</tr>
<tr>
<td>Seeing patients</td>
<td>9 times</td>
</tr>
<tr>
<td>Growing field/ expanding (hospitalists)</td>
<td>12 times</td>
</tr>
<tr>
<td>More/increase of hospitalists</td>
<td>23 times</td>
</tr>
<tr>
<td>Decrease length of stay</td>
<td>22 times</td>
</tr>
<tr>
<td>Repeat patients</td>
<td>2 times</td>
</tr>
<tr>
<td>Hospital System</td>
<td>16 times</td>
</tr>
<tr>
<td>Medical history/background (patients)</td>
<td>7 times</td>
</tr>
<tr>
<td>Electronic records/ health and medical records</td>
<td>16 times</td>
</tr>
<tr>
<td>Communication/ communication system</td>
<td>39 times</td>
</tr>
<tr>
<td>Navigators/coordinate</td>
<td>10 times</td>
</tr>
<tr>
<td>Liaison</td>
<td>2 times</td>
</tr>
<tr>
<td>Continuity of care/ quality of care</td>
<td>10 times</td>
</tr>
<tr>
<td>Control</td>
<td>5 times</td>
</tr>
<tr>
<td>Thirty day readmission rate</td>
<td>3 times</td>
</tr>
<tr>
<td>Consult</td>
<td>8 times</td>
</tr>
</tbody>
</table>

The next table will breakdown my viewpoint on what constitutes “financial terms” in relation to the role of the hospitalist as discussed in the literature review and interviews, as well as, how many times these terms appeared throughout the whole interviewing process.

- **Financial terms:**

<table>
<thead>
<tr>
<th>FINANCIAL TERM/S</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>15 times</td>
</tr>
<tr>
<td>Salary</td>
<td>5 times</td>
</tr>
<tr>
<td>Saving money</td>
<td>2 times</td>
</tr>
<tr>
<td>Money</td>
<td>18 times</td>
</tr>
<tr>
<td>Making money</td>
<td>1 time</td>
</tr>
<tr>
<td>Insurance/ insurance companies</td>
<td>10 times</td>
</tr>
<tr>
<td>Cost-effective</td>
<td>8 times</td>
</tr>
<tr>
<td>Costs</td>
<td>6 times</td>
</tr>
<tr>
<td>Thirty day readmission rate</td>
<td>3 times</td>
</tr>
<tr>
<td>Incentives</td>
<td>1 time</td>
</tr>
<tr>
<td>Paid/ cost saving</td>
<td>6 times</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>6 times</td>
</tr>
<tr>
<td>Economics/al/ally</td>
<td>3 times</td>
</tr>
</tbody>
</table>
**Literature Analysis:**

An extensive literature review indicates the majority of physicians view both the hospitalist and the hospitalist model as a benefit and challenge. As mentioned in the background section, physicians welcome the thought of having hospitalists help them take care of inpatients while they dedicate more of their time to outpatients. A research study looked at the communication with primary care physicians (PCP’s) who had referred their patients to the care of a hospitalists. The PCP’s reported they were more likely to report easy communication with hospitalists during their patient’s hospital stay than hospitalists’ communication with PCPs. Furthermore, the opposite was true in that the PCP’s reported more difficulty in communicating with hospitalists once their patients had been discharged.

Contrary to the physician’s viewpoint, advocates view the hospitalists’ job and role in the hospital setting effective in that they improve efficiency because they can monitor patients more closely and respond more quickly to changes in their condition. Some advocates also maintain the use of hospitalists to improve productivity in the outpatient care will allow any PCP to focus on them rather than their inpatients. In addition, advocates also believe that quality of the inpatient care may improve because hospitalists have more experience in managing inpatient care.

Literature suggests that many healthcare facilities find that having a hospitalist may be beneficial. Findings suggest that facilities with hospitalists may have an advantage regarding satisfaction with nursing and personal issues (eg, privacy, emotional needs,
response to complaints), both of which may be related to broader communication issues. Moreover, teaching (overall satisfaction) and large facilities (satisfaction with admissions, nursing, and tests/treatments) might especially benefit from the presence of hospitalists. The collection of these results were through the inpatient satisfaction surveys received in 2008, reflecting the experiences of 2,648,275 patients in 1,777 hospitals nationwide; 41% (729) employed hospitalists.

**NVivo9 Software Analysis:**

Based on the literature research and interviews conducted, which were then manually transcribed, I decided to use the NVivo9 software to code for certain terms that would fall under the two themes “quality” and “financial.” As previously mentioned in the Methods section under Data Analysis, the NVivo9 software was used to code for specific important terms or themes which the interviewer’s mentioned the most. Prior to coding for these themes or terms, I was aware of what to code because of the manual transcriptions which I conducted. Following the coding process, I constructed three bar graphs to further illustrate the perceptions of each healthcare provider in regard to “quality” and “financial.” These bar graphs can be found in Appendix C.

Figure one of the bar graphs depicts the percentage of quality terms coded by each interviewer. All the social workers were asked to provide quality terms regarding the role and care that hospitalists provide to their inpatients. Social worker #2 throughout his interview had 16.79% terms related to quality. In the same fashion, social worker #3 had 8.28% while social worker #1 had 7.94%. Both physicians #1 and #2 where respectively right behind the social workers with 6.93% and 6.62%. The only hospitalist interviewed
throughout this project had 6.44% while the nurses were the last individuals. Nurse #1 had 5.14%, nurse #2 had 3.37, nurse practitioner #1 had 3.12% and nurse #3 had 3.09%.

Figure two of the bar graphs illustrates the percentage of financial terms coded by each interviewer. Contrary to figure one there is no consistency of having the same healthcare providers aligned together but rather a variety of the specific healthcare providers spread around even. Physician #2 leads the way by having 7.67% of the financial terms being coded in relation to the role and care that hospitalists provide to their inpatients. Social worker #2 has 6.59% while nurse #3 has 5.90% of the most coded financial terms. Immediately following them is social worker #1 with 5.86%, nurse practitioner with 4.55%, the only hospitalist with 2.86%. The last four individuals were below 2%. Physician #1 had 1.48%, social worker #3 had 1.42%, nurse #1 had 1.20% while nurse #2 ended with 0.62%.

Figure three depicts the overall percentage of both the quality and financial terms coded by each staff. Leading this graph is social worker #2 with 23.38% followed by physician #2 with 14.29%. Next is social worker #1 with 13.80%, social worker #3 with 9.70% and hospitalist #1 with 9.31%. The last five individuals were below 9% starting with nurse #3 with 8.99%, physician #1 with 8.41%, nurse practitioner #1 with 7.67% and both nurses #1 and #2 with 6.34% and 3.99%.

Discussion of Findings

This section addresses some of the reasons as to why the interviewees responded the way they did regarding the questions they were asked. Last, I will also give input of my experience throughout this whole project along with my response to the hypothesis I
previously stated in the “hypothesis” section. Regarding question one, majority of the interviewees agreed that the roles of the hospitalists were to be navigators and their reasoning behind this response is because they know the hospital system very well. They further agreed that the hospitalists know where to direct patients and how to evaluate them to see if the patients are appropriate for either inpatient or outpatient criteria. They also saw the fact that part of their role is to communicate with the correct individuals who are a part of the inpatients’ care. The second question asked the interviewees if the hospitalist role has changed over time and most of them refrained from giving a definite answer while some guessed. For the most part, those who guessed and gave an answer of “yes,” their reasons were because the hospitalists have learned the role of most of the hospital staff along with the hospital system. They also feel that as the years have gone by the hospitalists have grown within the field. The interviewees further believe the reason these roles have changed and grown is because we are now seeing physicians who can’t afford to run their practices. Question three, a follow-up of question two, asked their opinions as to how they think the hospitalist role is expected to change in the future. The interviewees said that we would see more and more hospitalists. Some reasons for this are because more hospital systems, especially smaller hospitals which have had the traditional models, will go into a hospitalist model. Another reason we will see more hospitalists will be because PCP’s are not willing to learn the electronic medical records system because they are not likely to be using it a lot within the week. The next reason the field will grow is because recent medical school graduates will want to work for a hospital in order to get health benefits along with not having to pay for the office
overhead in their practices. The last reason they think we will see an increase in hospitalists is because it offers job security.

The follow-up question asked them what will be driving these changes and all of their responses hinted towards financial reasons. Their reasons to justify that these changes will be financial are because a salary hospitalist will be more beneficial for the hospital as opposed to having many private physicians, thus saving money. Another reason we will see more hospitals move into the hospitalists model is because they will be able to decrease the length of stay of their patients also saving the hospital a lot of money. This will further allow the hospitals to have better control of their environment and staff. Some of the interviewees see the insurance companies as well playing a role in the financial reasons. The next question asked is how do hospitalists address the needs of their patients as well as their outcomes, and I witness a lot of close yet different viewpoints in some aspects to their responses. They all acknowledge that the hospitalists do an effective job in addressing both their patient’s needs and outcomes, but have certain areas in which they can improve. A way hospitalist can address their patient’s outcomes and health is by getting to know their patients, and this is especially true if they are repeating patients. It also leads them to get familiar with what discharge resources their patients need. Another way hospitalists address their patient’s needs is by diagnosing the current health illness correctly. In terms of how the hospitalists address their patient’s outcomes, some interviewees said they looked at the length of stay and made sure their inpatients were not there longer than they are supposed to be. For the most part, since hospitalists are immersed in the hospital and they know how the hospital system functions, they can address their patients needs by directing them to the proper
individuals for any social, behavioral or mental needs. However, there were some interviewees that said hospitalists do a poor job in addressing the outcomes of their patients especially once they are discharged from their hospital.

Question six asked the interviewees their opinion regarding advantages and disadvantages between the traditional model over the hospitalist model. All the interviewees mentioned the same advantages and disadvantages and agreed that the hospitalist model has a lot more advantages overall. Some advantages of having the hospitalist model over the traditional model are that there is always a physician monitoring the care of the inpatient, they know the hospital system very well, can diagnose the patient rapidly and determine what tests to give the patient. Another advantage is that the hospitalist has more help than a PCP would since they are constantly mentoring residents and are in close proximity with nurses. The interviewees saw very few disadvantages in having a hospitalist model over the traditional model. A disadvantage that some of them saw was the lost of continuity of care by the hospitalist once the patient has been discharged. In the same fashion, some of the interviewees saw the communication piece as a disadvantage or an aspect the hospitalist could potentially improve on. The next question asked how much communication is there between a hospitalist and PCPs? A majority of the interviewees either responded with “not enough”, “depends” and “enough”. The rationale behind these answers is based on their experiences and the close work relationship they have with the hospitalists. The reasons some said “not enough” is because the hospitalists sometimes forget to make a call or fax especially if they are extremely busy. Another reason they said “not enough” is because some PCP’s don’t have electronic health records (EHR) readily available to them unlike
the hospitalists do. Other interviewees said “enough” and their reason was because both the PCP and hospitalist have the hospital EHR since they are both employed by the hospital.

The next question asked the interviewees their viewpoint as to what they saw as advantages and disadvantages of the current communication system between the hospitalist and PCP’s. Once again the interviewees stated mostly the same advantages and disadvantages. An advantage is that continuity of care will be better especially if both the PCP and hospitalist are employed under the same hospital system which has an EHR. The opposite, however, is true, and it can be a disadvantage as well especially if the PCP does not have EHR thus making the continuity of care for the patient more challenging. Question nine asked which areas do they think hospitalist appear to be the more effective as well as less effective in a hospital setting. All the interviewees agreed that the hospitalist appear to be more effective when dealing with acute illness and less effective when it comes to a specialty that is out of their focus of practice (eg, cardiac surgery). The next question asked for their thoughts on whether the hospitalists have proven to be cost-effective in their hospital and if so, how. An overwhelming of the interviewees agreed that the hospitalist model has been cost-effective for several reasons. Once again it’s important to note that these individuals had no data readily available to them or have not seen any data. These individuals are basing their response again on their experience having worked at a hospital system that has the hospitalist model in place. A reason they believe it’s cost-effective for the hospital is because they are effectively decreasing the length of stay of their patients thus addressing a performance
indicator hospitalists get evaluated on. Another reason the hospitalists are cost-effective is because the hospital has seen fewer denial rates.

Overall, after much literature research, conducted along with the interviews, I have come to a response regarding my hypothesis. My conclusion is that hospitalists are in fact a good model to be implemented in all hospitals because they have, indeed, improved the quality of inpatient care in hospitals where the model has been implemented. At the beginning of the project, I must admit I was not sure and was for the most part limited in my response because of the conflicting viewpoints encountered in my literature research. Once I conducted the interviews I was still hesitant in committing myself to a response. My response was realized once I closely dissected the interviews and weighed all the advantages along with disadvantages regarding the hospitalist model and hospitalists. For the most part, I share the same feelings as some of the interviewers regarding the hospitalists because they have, in my view, decreased the length of stay of their inpatients along with costs even though I was not successful in finding appropriate literature to validate my response.

I truly feel that the only disadvantage of the hospitalist model is the hospitalists need to improve the communication piece. I am basing this opinion not only because the literature research indicated that as a flaw but also the interviewers. Furthermore, I also believe that a way to address this issue of communication is through the implementation of electronic health records. I will definitely be curious to see how the Affordable Care Act (ACA) along with the mandatory implementation of EHR impact the communication between a hospitalist and PCP’s. I believe once the EHR is implemented the continuity of care for all patients will be better and result in being cost-effective. Last, I believe, in
general, that the hospitalist model has been effective now and will continue to be
effective in terms of addressing the length of stay and costs in the near future because the
hospitalist model was not effective, it would not have lasted the time it currently has.

Throughout the course of these interviews, I was impressed with the commonality
of all the interviewers’ opinions. It didn’t seem to matter whether the staff was from
Cooper Health System or the Camden Coalition Center because there seemed to be a
general belief that the hospitalists are a benefit not only for the hospitals and PCP’s but
most importantly, patients. After finishing this study, I still left with some questions
unanswered. I would have wanted to know actual data concerning the cost-effectiveness
on how exactly hospitalists have helped both hospitals and inpatient care. It seemed to
me from the literature and interviews everything was based on opinion rather than actual
facts. I also would have wanted to get more hospitalists’ viewpoints regarding their roles.
I truly believe that this study, although well organized and illustrated, would have
merited a better comprehension of the role of the hospitalists in the hospitals if more
hospitalists were involved in the interviewing process.

In the same fashion, I cannot help but wonder what other specialty or field will
soon follow behind or replicate the hospitalist model. As I discussed throughout this
study, the hospitalist model evolved from two primary concerns: length of stay and
inpatient costs, but the hospitalist role increased as the PCP’s began to get more pressure
to visit their patients in a hospital setting and provide adequate care for outpatients. A
more recent field coined as “laborist” is being considered as an alternative to help
obstetricians/gynecologists (OB/GYNs) in the same manner the hospitalist model has
benefited the PCP’s. This field was created in 2005. Literature suggested that improved
patient outcomes and patient satisfaction with the hospitalist model of inpatient medical care coupled with the desire to improve provider satisfaction led to the introduction of the laborist in obstetrics.\textsuperscript{23} This represents a significant change in the way obstetrics has been experienced and practiced from both a patient and provider perspective. The laborist was designed as a plausible model of obstetric care delivery where hospitals employ physicians to provide continuous coverage of labor and delivery units without other competing clinical duties. Anecdotal use of the laborist model in the provision of obstetric care is growing rapidly despite the lack of research regarding its impact on maternal outcomes, neonatal outcomes, patient and provider satisfaction, and graduate medical education. This new field is going through and will continue to go through the same criticisms that the hospital model has gone through such as: OB/GYNs being resistant to the laborist model, as they perceive laborists as a threat to their existing practices.\textsuperscript{23} This strong opposition has precluded many administrators from adopting a full-scale laborist model.

**Policy Recommendations**

This last section will provide my recommendations as to what can be further done to explore and address the role of the hospitalist and hospitalist model along with the communication aspect. These recommendations are based mostly on the fact that there is little to non-existent research that has been conducted on the hospitalist model. The following recommendations proposed in this section are geared to give the hospital industry and government some suggestions on what exactly they could focus on:

- The potential contributions of hospitalists to patient care merit further study and evaluation. This study and evaluation can be funded by the government (AHRQ) or a private foundation (eg. Kaiser Foundation). Doing a study of this magnitude can also
access if the hospitalists are indeed having a positive impact on the patients quality of care along with being cost-effective.

- The Medicare program should provide significant leadership in the area of hospitalists’ research by sponsoring one or more demonstration programs designed to assess the contributions of hospitalists to the many dimensions of inpatient care.

- Funding for AHRQ be increased for research related to the role of the hospitalist in inpatient safety and quality. Hospitalists recognize AHRQ’s vital role in improving the quality of our nation’s health and should continue collaborating with the agency on a number of its projects.

- AHRQ to study the impact of hospitalists on reducing medical errors. Congress should direct AHRQ to study how hospitalist programs reduce medical errors and improve patient outcomes. If the study identifies successful practices and procedures that achieve these outcomes, this would advance adoption of hospitalist programs.

- I also recommend that hospitals and more healthcare agencies utilize hospitalists more in a hospital setting being that not all hospitals have a hospitalist program in place. As it is right now where the hospitalist program has been implemented the hospitals have seen a decrease in length of stay and costs.

- From the communication aspect that AHRQ or private foundation funders take the initiative and conduct more studies on how to improve communication between hospitalists and PCP’s and to determine what clinical elements are important to receive within two days of discharge or immediately following admission. It is true that EHR will end up improving the communication aspect but it will not take into effect until 2014.

- To improve communication, the hospitals should standardize the faxing process with the unit clerks and front line staff.
- To facilitate communications, the hospitals should also identify ways to better Identify the PCP at the time of discharge.

References

1. Goldman, 2003. Hospitalists as Cure for Hospitalism. This article states the two most common reasons for the development of the hospitalist model. They were originally inpatient costs and lengths of stay. Over the years they have seen other key components as to the rise of the hospitalist model. They are as follows: physicians feel they were more prepared than most of them to care for an increasingly sick inpatient population, the need of PCPs to also see their inpatients several times per day.

2. Pham et al., 2004. Healthcare Market Trends and the Evolution of Hospitalist Use and Roles. This article states many other reasons besides inpatient costs and lengths of stay as the rise of the hospitalists’ movement. These other reasons were time pressure on PCPs and increasing complex inpatient medicine.
3. Reid et al., 2011. Mentorship, Productivity, and Promotion Among Academic Hospitalists. This article simply states the type of education hospitalists usually receive. They primarily go through the same route as any PCP. It further discusses the fact that hospitalists are no different than physicians and non-physician providers regarding engaging in clinical care, teaching, research, or leadership in the field of general hospital medicine.

4. Coffman et al., 2003. The Impact of Hospitalists on the Cost and Quality of Inpatient Care in the United States: A Research Synthesis. This article points out that the first hospitalist program was first established in 1994 by Park Nicollet Clinic, a large multispecialty medical group located in Minneapolis-St. Paul. They further discuss also how teaching or academic hospitals began to use this model and where.

5. Wachter and Goldman, 2002. The Hospitalist Movement 5 years later. This article depicts just how much of an impact the hospitalist model has had since its beginnings. From 1996 to 1999 65% of the internists had hospitalists in their community while 28% of these internists or PCPs reported using them for their inpatient care.

6. Lopez et al., 2009. Hospitalist and the Quality of Care in Hospitals. This article demonstrates the fact that As of 2008 there were 20,000 practicing hospitalists with a potential of reaching 40-50,000, which eventually will surpass cardiology in size. They further suggest that these numbers will undoubtedly keep increasing since more and more physicians are constantly using them. Along with this more future academic medical students see this as a less stressful job or demand on them.

7. Harrison and Curran, 2009. The Hospitalist Model: Does it Enhance Health Care Quality? This article makes reference to the fact that the eastern United States has the highest penetration of hospitalists at 31% while the western United States has the lowest penetration of hospitalists at 21%. According to The Society of Hospital Medicine the average hospitalist also sees more than 2,400 patients annually and is only compensated with an amount of $193,000.

8. Pham et al., 2004. Healthcare Market Trends and the Evolution of Hospitalist Use and Roles. This article looks at three specific locations and explains why they have seen the
use of the hospitalists’ model in use. These three locations were in Orange County, California, Phoenix, Arizona and Miami, Florida.

9. Wilson, 2008. Are inpatients’ needs better served by hospitalists than by their family doctors? This article emphasizes the many reasons as to why the rise of the hospitalist model occurred. The contributions were due to the diminishing of community family doctors along with the difficulty in them squeezing hospital rounds into their expanding workdays.

10. Sanchez and Sariego, 2009. The General Surgeon Shortage: Causes, Consequences, and solutions. This article states just what exactly a local Philadelphia hospital known as the University of Pennsylvania attributed the use of hospitalists. This attribution was due to the shortage of general surgeons.

11. Srivastava et al., 2005. Community and Hospital-Based Physicians’ Attitudes Regarding Pediatric Hospitalist Systems. This article examined both the attitudes of the community and hospital-based physicians through a questionnaire as to whether the hospitalist model is an effective tool or not.

12. Fulton et al., 2011. Patient Satisfaction with Hospitalists: Facility-Level Analyses. This article states other facts besides length of stay and costs as to why the hospitalist model saw its beginning. They state that the rise of hospitalists was because of the increased acuity of the hospitalized patients and the accelerated pace of their hospitalizations.

13. Baudendistel and Wachter, 2002. The Evolution of the hospitalist movement in the USA. This article along with the other ones that are cited throughout this proposal primarily suggest that inpatient costs and lengths of stay are responsible for the evolution of the hospitalist model. They also further suggest the cost pressures on health plans were another factor as well.

14. Pham et al., 2008. Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care. The author suggests that as a result of the hospitalist movement along
with their reasons they could potentially improve the quality of care of specialty and surgical patients which in turn makes it easier for policymakers and PCPs.

15. Baudendistel and Wachter, 2002. The Evolution of the hospitalist movement in the USA. This article just like the “Hospitalists and Care Transitions: The Divorce of Inpatients and Outpatients Care” article suggest a series of results that the hospitalists movement were able to show as a result of their existence. This article suggests that patients are more willing now to trade familiarity for the availability of the hospitalists since they are readily available.

16. White and Glazier, 2011. Do hospitalist physicians improve the quality of inpatient care delivery? A systematic review of process, efficiency and outcome measures suggests that as a result of the hospitalist movement the on-site availability of a hospitalist ensures that a dedicated provider is readily available to answer questions, order along with manage tests while also responding during any medical crises.

17. Pham et al., 2008. Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care. In this article the author along with benefits also suggests challenges/negatives to having a hospitalist program. It suggests that implementing the hospitalists’ model in the healthcare system coordination becomes more complex for the patient by simply increasing the number of providers and organizations involved in the hand-offs of patients. There are other reasons as well which can be encountered throughout this article.

18. Ruth et al., 2011. Evaluating Communication between Pediatric Primary Care Physicians and Hospitalists. This article overall gives us another challenge as to having a hospitalist program. They suggest that having hospitalists accept patients from their PCPs at the time of admission to the time of discharge may produce variable levels of discontinuity in care which could potentially raise a concern when it comes to increased patient morbidity.

19. Glasheen et al., 2008. Fulfilling the Promise of Hospital Medicine: Tailoring Internal Medicine Training to Address Hospitalists’ Needs. This article states how the hospitalist model has evolved from 1996 up to now. They further state what hospitalists along with
hospitals are now doing. It suggests that 68% hospitalists now participate in quality improvement initiatives. On top of that another article suggests that 59% of the hospitalists play a part in formal utilization review, and 54% are also involved in hospital electronic medical records and computer provider order entry initiatives.

20. Vidyarthi et al., 2006. Managing discontinuity in academic medical centers: strategies for a safe and effective resident sign-out. This article also gives us a look at how the hospitalist model is evolving as the years go on and how they are conforming to these times. According to the article hospitalists are also currently involved in improving their patient handoffs by partnering with outpatient providers especially in the care of complex medical patients.

21. Pantilat et al., 2006. Evaluating the California Hospital Initiative in Palliative Services. This article along with the other 2 precious articles cited looks at how the hospitalist model has evolved. The hospitalists according to this article are also involved in developing hospital-based services such as palliative care and rapid response teams.

22. Scheinwald and Aronson, 2007. Implementing a Laborist Model: Four Case Studies. The article focuses on how the hospitalist model has help shape this new field and address the role of the laborist within the hospital system. It further eludes many challenges it faces just as the hospitalist model has faced.
APPENDIX A: STRUCTURED INTERVIEW QUESTIONS

The Role of Hospitalists in the Healthcare Industry

Interview Instrument

Introduction

Thank you for taking the time to speak with me. My name is Arkel Gordon. I am a public health graduate student at Drexel University School of Public Health. This interview is taking place during my community-based Master’s project at Drexel University. The purpose is to provide me with a birds-eye view of the current use of hospitalists in the Philadelphia healthcare system. I am seeking your input on what kinds of problems and/or advantages arise from the hospitalist model as in use at your institution. Which of these problems you consider most urgent, and what kinds of opportunities you believe exist around these issues. This information will be used to complete a study of these issues. All your responses will be kept strictly confidential. They will not be individually identifiable, recorded for public use or subject to public release. Do you agree to begin the interview?
What are the roles of the hospitalist in the healthcare system?

How have these roles changed over time?

How are these roles expected to change in the future?

What has been or will be driving these changes?

How do hospitalists address the needs of their patients and outcomes?

What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?

How much communication is there between a hospitalist and PCP’s?

What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?

Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?

Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

Are there any additional questions or suggestions that you have for me?

APPENDIX B: INTERVIEW TRANSCRIPTIONS

Interviewer: I just wanted to first thank you for being willing to speak with me today. Before we begin, I will go ahead and reiterate what this study is about, and again if there is anything that you are not clear about or if I’m speaking too fast feel free to stop me at anytime. So again the purpose of this study is to provide me with a birds-eye view of the current use of hospitalists in the Philadelphia healthcare system. I am seeking your input on what kinds of problems and/or advantages arise from the hospitalist model as in use at your institution. Which of these problems you consider most urgent, and what kinds of opportunities you believe exist around these issues. I hope that this information can help me in further developing my hypothesis. You again can stop me at any time, if there are any questions that you don’t feel comfortable responding to you can definitely ask me to skip over it, it won’t affect your treatment or anything. Do you have any questions before we start?

Social Worker #01:

Question 1: What are the roles of the hospitalist in the healthcare system?

Their goal is to act as the physician that follows the patient once they are admitted to the hospital. We have probably I would guess fifteen to twenty hospitalists and they share an office
upstairs actually. I am very happy with the role they serve and we have good relationships with them. We rely on them and it’s a give and take from a social worker’s perspective because they give us directions on what the patient needs. An example would be if a patient needs to be discharged to a nursing home or to a rehabilitation we then take it from them. We get our direct referrals from the hospitalist. Overall, it’s a nice relationship.

**Question 2: How have these roles changed over time?**

That’s an interesting question. I’m not sure that they have changed. I think that the hospitalists are the do all. They are the go to doctors and the point person. I think definitely the all consult to all the specialists in the facility. They deal with everything and an example would be a social issue. A lot of social issues they deal with are constantly being referred to a social worker. Overall, I don’t know if that’s going to change or not. I think from my perspective that the hospitalists have learned our role which is the social workers and they utilize us appropriately.

*Side Question: So, do you think they have stayed consistent in their role.*

Yeah, again I think and I’ve been here for five years and I have not seen it from the beginning but I would imagine that it has expanded. I can also tell you there is less private physicians coming into this facility and seeing the patients. This would lead me to say that the hospitalist role has definitely expanded.

**Question 3: How are these roles expected to change in the future?**

I think it would just grow.

*Side Question: Can you expand on what you mean in terms of growth.*

It will grow in terms of enrollment and people getting medicine. There will be minimal private physicians in the facilities and more hospitalists controlling, seeing and doing it all. I really see it expanding and growing.

**Question 4: What has been or will be driving these changes?**

I think financial is a key piece.

*Side Question: Financial in terms of how.*

Well I would imagine if you have a salary hospitalist as oppose to a private physician or if you have to utilize the specialist you will be saving money. They will also follow the cases more closely and they have a buy in to the facility as oppose to the community. This can be a buy in terms of decreasing length of stay and when you’re on a patient you can expedite a discharge and in turn save the facility a lot of money. This more seeing if the patient doesn’t have a medical reason to be here the reimbursement goes way down and you save a lot of money. That’s probably the key factor and it’s always financial from my experience. If you can show that
you’re saving or making money then that’s always going to be a deciding factor. In return from a patient care perspective I think our patient will get better care from seeing the hospitalist here. They will see them every day, know them better and get to know their complex medical issues. The community doctors may not be comfortable in an acute care setting.

**Question 5: How do hospitalists address the needs of their patients and outcomes?**

I think they get to know their patients especially since we have a lot of repeat patients. This in turn leads them to get familiar with what the discharge resources are via rehab, home health. Overall, they are savvy and get to see the patients on a daily basis as well. If you have a savvy physician who can manage as a point physician in an acute care setting and know that they have to get this patient ready for discharge and quickly. This will benefit the hospital, patient and the community to know the acute illnesses and risks along with complications that patients have. On the contrary to a community doctor who may not be up to date in knowing the equipment and even knowing the different in house options as far as with all the specialty care. An example can be psychology and I don’t know how many community physicians would refer to a psychologist. This is something that are hospitalist routinely do. Utilizing the team by using social workers and doing care coordination in case management.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

The advantages will definitely be financial. This is obviously a repeating piece on patient care. Here we try to utilize patient center cares so that definitely encourages patient center care because we have someone who knows their case along with their complexities of it. They also know how to work a hospital system as well where the community doctors don’t have that advantage. I don’t think the community doctors know where all the resources within the hospital are. I don’t even know how they use them either. I rarely get referrals from a community doctor. As far as disadvantages I don’t know if there are any. I guess you can say if I’ve been a patient of a doctor or a PCP within the community for 25 years, I guess knowing that medical history with electronic records but you can’t even say that anymore. Another disadvantage could be the knowledge of the patient and it’s dangerous too. An example can be if a PCP knows that Mr. Jones has an underline medical condition that may not have been his chief complaint but it came to the hospital its risk and dangerous.

**Question 7: How much communication is their between a hospitalist and PCP’s?**

Not enough communication at all I think. I think this is always the issue when you have large facilities, large volume of patients and incredible pressure to move patients through the system communication sometimes gets lost. This is something that even with me sharing an office upstairs with them the hospitalists sometimes very difficult to communicate with them social service needs, barriers to care, barriers to discharge and to have a good give and take. This is the key piece. We have been trying for example to get our hospitalists to sit on our complex
discharge sitting committee and finally they are but it took five years. There is also some turnover and some transition and that’s when we are starting to build good relationships with certain hospitalists. They simply move on. Communication is always a big barrier. We can always increase and improve our communication.

Side Question: So would you consider that a disadvantage as well then.

I think it’s a need for improvement but not a disadvantage.

Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?

Again as I was saying I see less and less PCPs here and I am not sure of what the numbers are but I would say nine out of ten is a hospitalist driven patient here. I see an advantage that they can communicate with other doctors. Then again most of our patients don’t have primary care that’s one of my goals is to connect them to a primary care. A disadvantage can be that the hospitalist or PCP’s are so busy that sometimes it’s hard to communicate with each other. An example would be in a worst case scenario if the doctor is on vacation and we cannot reach them.

Side Question: So do the hospitalists themselves communicate with the PCP’s or is it up to the social worker.

No the hospitalists do because that’s a doctor to doctor communication like it should be. Our emergency department doctors do it as well.

Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?

They appear to be best served in terms of knowing the hospital system so I think navigating a patient through their stay is what they are very good at. Getting them from the point of admission to the point of discharge in an expeditious direct way with the best medical care but also keeping in mind the bottom line the financial responsibility. By financial responsibility I mean the length of stay piece, the Medicare value length and all of that stuff they navigate patients through this facility. That’s by far their most important role I would imagine. As far as areas they are less effective I don’t see any really.

Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

Oh, yeah. Well like I said before let’s just look at the length of stay piece because they have a buy in because I’m sure there is financial considerations from their end from this facility that if you can get length of stay down and those days down along with those wasted days that a patient is sitting on a bed and not really having a medical need to be in a bed that saves this hospital a lot
of money. This also has the effect of also making the hospital money too because you are filling
the bed with someone who is acutely ill versus somebody who is just waiting for a physician.

**Question 11: Are there any additional questions or suggestions that you have for me?**

I want to go back on the communication piece. This is definitely something if possible if you
can make a recommendation to figure out a way to improve that barrier that would be a long
term recommendation. To have hospitalists be more available or to sit on more committees as
well.

**Social Worker #02:**

**Question 1: What are the roles of the hospitalist in the healthcare system?**

My understanding of the role of the hospitalist is too really help evaluate. So many patients
come in to the hospital and the hospitalist will really act as a liaison between the primary care
doctor as well as specialty care teams. They also seem to be a little bit of a navigator in
determining what are the patient’s medical issues. An example can simply be have the tests been
done if not who needs to do them. Overall, they would know where to direct them and
evaluating to see if the patient is appropriate for inpatient criteria or if something can be done on
the outpatient side. An example of outpatient can be by let’s say looking to do see if they really
this level of medicine in mind.

**Question 2: How have these roles changed over time?**

Oh, I don’t know at all. I’m not sure. I would imagine that the roles have stayed the same and
grown.

*Side Question: What do you mean by grown.*

By grown I mean in size. In other words more and more hospitalists are being hired and it’s
becoming a popular trend.

**Question 3: How are these roles expected to change in the future?**

Again, the potential of growth or expansion within this field. I think you will also see more and
more hospitalists play a major part in the healthcare of their patients more than they are now.
They are definitely expected to change in the future for a good cause.

**Question 4: What has been or will be driving these changes?**
Insurance companies is my belief. I think in the end are you interviewing any hospitalists for this. I think anybody will tell you is typically the insurance companies and hospitals employee hospitalists to help them. It's like a system of checks and balances. Overall, I think it’s more of a financial reason. Another possibility could be that it gives these individuals a steady salary, along with steadier hours and a slot of case loads. This is all essentially managed care and they will be designated certain patients to monitor. They will also be acting as a liaison between the specialty care within the hospital.

*Question 5: How do hospitalists address the needs of their patients and outcomes?*

That’s a hard one for me to say. I think essentially they are very thorough looking at it from a third party perspective and they are often willing to make phone calls and collect collateral information. Like I said earlier before they are navigators. For example, they can be that individual who can talk to the cardiologist or the primary care doctor about the patient’s status.

*Side Question: Right, going along those lines according to my literature I have read that there has been a discrepancy about this issue. So with that said do you think hospitalists misdiagnose or rely on technology too much.*

Your in a hospital so if the patient is meeting criteria to be in a hospital that criteria is already been established by the insurance company. I mean I don’t really feel that I am qualified to make or answer that question. I do think, however, a lot of it is insurance driven. They need to look at this model and say why insurance companies have suggested this model.

*Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?*

An advantage of having the hospitalist model is that it gives you a new fresh set of eyes and frankly I’m sorry primary care is growing more and more extinct. I don’t think primary care is doing a good job. Right now I would imagine that there are people that genuinely think that primary care doctors get kick backs from the referrals that they make not realizing that in your own practices a lot of the primary care doctors aren’t comfortable recommending certain tests or reviewing test results and that insurances discourage them to do it. I think with this happening more and more you see less people going into primary care to get a primary care. I think if we have a patient that meets criteria to come into the hospital I think it is advantageous because you have somebody with that understanding and that knowledge that are willing to look at the records. I mean with many insurances you don’t even need a primary care doctor. I mean think you really need to look at the insurance piece because if you have a PPO you don’t need a referral. A disadvantage is that they are not in the community. I guess that you never see them again and you lose communication with them unless they are repeated patients. I think one of
the issues is that we are not seeing enough continuity of care in healthcare and for that matter in getting to know their patients.

**Question 7: How much communication is there between a hospitalist and PCP’s?**

I think if they coming in during business hours most of the hospitalists might or might not. I can give you an example like when the ED covers the Observation Unit Program that the social work does. With this said I see them a lot of times calling because a lot of these patients don’t even know their medical issues, medications or they don’t understand the connection. I think they are pretty good about calling and gathering information.

**Side Question: How about relaying the information.**

In terms of relaying the information is where I don’t know. I suspect many primary care doctors don’t even know their patients were at a hospital. I guess their probably is a need for improvement. This also depends because now we have technology. For example with us we have Medical Records now and it’s centralized. At some point we will all get access to each others medical records and I really think that’s the way to go. There is the negative about this, however, we have to remember does the doctor really have time to read all these charts.

**Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?**

I think number one the main communication system is technology and we all have access to one another’s information. Suppose a patient’s doctor is on vacation and they have a heart attack and the patient doesn’t know their medication. If they are a hospital-based employed doctor we can see everything that this patient is getting prescribed. I think this just enhances communication in instances where it is one o’clock in the morning and you don’t want to page the doctor or call at home. If the doctor is at home they are not expected to have access to their patient’s medical records. This could be a disadvantage. Another disadvantage is that it’s a lot of information to read. You’re living in a world that is driven by time and need to meet certain needs which then effect the communication. A lot of times things when we put it in writing are subject to interpretation. You always want to cross check and make sure your understanding what they wrote.

**Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?**

Again I work in the ED and I don’t really walk up on the floors or let alone have experience on the floors with them. Off the topic I think they appear to be best served during observations, med surge and all your basic medical issues. After this I think you need specialty care and they would know where to direct them. As far as areas they are less effective I don’t really see any at all.
**Question 10:** Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

I think so. Again it’s somebody reviewing tests and reviewing what was ordered. They are also seeing what hasn’t been ordered. The bottom line is the value is human life. I think it absolutely has to be cost-effective because they are there constantly monitoring what’s the patients length of stay and what’s been done as well. Overall, I think everyone of them wants to be seen as cost-effective. I definitely believe so. They are primarily there to decrease length of stay and costs. I don’t know if having an actual hospitalist will cost less than having an actual PCP coming in but I would imagine it could. We have length of stay meetings and other meetings that discuss with them that at this point in time this patient is exceeding healthcare costs.

**Question 11:** Are there any additional questions or suggestions that you have for me?

I really think that in your paper you really need to look at how insurance policies affect healthcare costs. I know this might be a thesis on its own but I just think it will be beneficial. I think there is too much regulation by insurance companies. I really think it’s overly regulated.

**Social Worker #03:**

**Question 1:** What are the roles of the hospitalist in the healthcare system?

I see the hospitalist role as the doctors that are in the hospital that takes care of a patient that really doesn’t fit a model as an example, cardiology or any type of specialist. I see them as the doctor who is taking care of the patient with multiple or not a specific diagnose.

**Question 2:** How have these roles changed over time?

I personally don’t think they have changed but then again I am not as intensive working with them as I used to be. I really can’t answer that because now I am in an office and all I do is call them once a week and even then I can’t get a hold of them.

*Sidenote:* Ok, but from your experience when you were working in a hospital setting has it changed.

Personally, I used to have a hard time getting a hold of them even while in the hospital. We would get a daily sheet that will tell us who is taking care of a certain patient and what day because the hospitalist alternate. In the beginning I used to think it was very confusing because if I don’t get that email with the list that morning I am lost the whole day because most patients are on the hospital. After a while I got used to it but even with that it’s still a little bit hard because you still have to look at that sheet.

**Question 3:** How are these roles expected to change in the future?
I think they have the hardest job between a specialist who is dealing with an orthopedic or a pediatric versus a hospitalist. I think they have the hardest job because they are jumping from this wing to get to the other wing and so on. I think it’s pretty hectic and I predict they will have more on their plates. I see it as a growing field because there is a need for it and not everyone falls into a specific diagnose.

Question 4: What has been or will be driving these changes?

Hopefully concerns for the well being of the hospitalists. I see most of them burned out and stressed. I also think the big thing that will drive these changes are financial as well.

Question 5: How do hospitalists address the needs of their patients and outcomes?

They do it wonderful and I think they do the best that they can. They are there when you need them and of course depending on if they are in a meeting or not. They do a great job as much as they can and they try to be there as much as they can. They are a big part of the hospital because we need them to diagnose the patients and tell us where they go. They ultimately serve as navigators.

Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?

Advantages are that there is always someone that is going to be there because they alternate. No patient is going to be left behind or untouched. Another big advantage is that they are the ones with a lot of students. They have all types of students from residents who they are teaching and so on. They have a lot more help and they also try to be everywhere. That is also a disadvantage because by them trying to be everywhere you can’t get a hold of them sometimes. An advantage is that you get the best doctors because they learn about almost every area within the hospital and medicine. When it comes to diagnosing a patient that’s a big advantage. The communication aspect between a hospitalist and PCP depends. I have really good ones that follow up and others that make appointments with primary cares and inform the patient they need to go to see them ASAP not wait a month later. I know some of them follow-up on their patients and see how they are doing health wise.

Question 7: How much communication is their between a hospitalist and PCP’s?

Not enough, the individuals I have been talking about are hospitalists that literally go out and above for their patients, but most of them because they are so burnt out and stress they really don’t follow through with their patients. They would sometimes write on the patient’s discharge to follow up with your PCP. It goes both ways; however, it could be also that PCP’s are not listening to their messages as well.

Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?
A disadvantage is that no matter the system in place their will still be people or staff that will not follow through. If the right electronic health record is in place I feel that the communication will be effective but even with technology there is some things that need to be trouble shoot in order for the electronic medical records to be effective. An advantage is that I love it because I know from a patient’s end how long they have been in and I know primary care physicians are using it. Another disadvantage will be that the patient’s information is all over but at the same time it’s very secured. I don’t think there is enough communication which is a disadvantage. Along with this I think a disadvantage is that this system is only able to be retrieved in the hospital setting not at home.

Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?

They are very effective when a patient is admitted right away in that they see a doctor. For example, if you come in with chest pains but it’s really not chest pain and we have to figure out what’s wrong then they are effective immediately in diagnosing you correctly. If you need a specialists they know how to navigate you as well. I think they less effective in the communication aspect.

Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

I have seen both instances where it could be cost-effective and not. It is because PCPs don’t have to travel and can focus on their outpatients more. Furthermore, I can see it being cost-effective because you’re hiring a salary hospitalist instead of relying on a PCP to come in.

Question 11: Are there any additional questions or suggestions that you have for me?

Going back on the communication aspect I think I see that as a need of improvement and not necessarily as a disadvantage.

Physician #01:

Question 1: What are the roles of the hospitalist in the healthcare system?

In general the role of the hospitalists are to take care the healthcare needs of the patient when they are hospitalized. Along with this because they are part of the hospital they have a good idea of the inner workings of the hospital. They have also a good idea on how to communicate with the correct individuals who are in the hospital more often. Basically, though there role is to take care of the needs of their patients when they are hospitalized.

Question 2: How have these roles changed over time?

I don’t know if they have changed significantly. I think it depends more on the institution and they might have changed more because of the institution. In many places I’ve only seen
hospitalists at academic centers where they also have residents available. I have not worked in institutions where there are no residents and I think that may have changed. Seeing the hospitalists not only as people who are taking care of their patients in a hospital but also being around more for the academic education so their training of students and residents.

**Question 3: How are these roles expected to change in the future?**

I think you’re going to see more hospital systems or more places go into a hospitalist model and again I have no data to back this up. I don’t know if within the hospitalist model it is going to change. I would expect it to be more hospitalists and more of a division of labor where the outpatient doctor does the outpatient thing and the inpatient doctor does the inpatient thing. Overall, I don’t expect it to necessarily change a lot. I think you will find smaller hospitals which have had the traditional models where the primary care provider comes into the hospital and sees them and then takes care of them there and then proceeds to go back to their office to diminish. In other words I tend to think you will see less and less of that.

**Side Question:** So is it safe to say or assume that the primary care physicians would be almost extinct because of the hospitalist model.

No, they are not extinct and will never go extinct because they are doing primary care and then outpatient. They may a select group of patients. For example it may be somebody that they take care of and then there is other people that have the hospitalist.

**Question 4: What has been or will be driving these changes?**

I think that for one you will find that if the hospital employs the hospitalists they will have control over that aspect. They will not have to worry about if the primary is going to be admitting a patient to the hospital and who is not admitting so this will become more of a close system. They can control the quality of care that’s delivered. I also think that it’s becoming more and more challenging to be the primary care provider because you will need to get to the hospital at six in the morning and see patients until eight or nine and then get back to the office and see patients all day and every day. There are great things by having the physician you know come and see you in the office and the hospital but you’re also there for a limited amount of time. People nowadays are in and out of the hospitals quicker so to ask a primary care to come in and admit a patient and to see them each day in forty eight hours turnaround and discharge them is difficult. As a result of this you have the hospitalists who are there.

**Question 5: How do hospitalists address the needs of their patients and outcomes?**
That’s a good question. Medicine is going to be moving much more towards outcome driven or quality driven processes I think hospitalists will have to follow those same things. One thing that hospitals are very good at looking at is the amount of time to discharge in other words the length of stay of the hospitalization. This is a factor which has financial implications and I think over time you’re going to see much more for this type of special performance. In other words they will look at where is the thirty day readmission rate for these patients and then sub dividing it. What is the thirty day readmission rate for congestion heart failure and the hospitalist like everyone in medicine is going to have to gulf this. This will not only be true for hospitalists but also for everyone who admits patients and takes care of them.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

The advantages are that you have somebody who knows the hospital system and knows who to talk to like a social worker. They are in the hospital all day long so they can stop by and see the patient in the afternoon. For example, they admit a patient who has pneumonia and they are put on steroids and what if they can check on this patient again and again. If a problem does arise they are there to take care of the patient while they are at the hospital. This makes it much easier for nurses, social workers and whoever they need to talk to in order to take care of things. The physician who is in the office probably if the patient gets a CAT Scan might get a call from the radiologist. I think overall the hospitalists have a much greater presence in the hospital. There is a disadvantage in that they don’t know the patient as well. So they come in and things may have been tried and as an outpatient you don’t want the hospital doctor stumbling through or figuring that out. For the hospitalist model you need excellent communication for the primary care provider to the hospitalists which I’m guessing doesn’t happen most of the time. From the primary care provider perspective somebody shows up in the emergency room and they get admitted maybe the hospitalist will give us a call as their PCP but it’s obvious that the PCP doesn’t even know that their patient is in the hospital therefore they can’t communicate. I think better electronic health records and the way that information exchanges will help in bridge that communication barrier. Another disadvantage is that they might give unnecessary tests that don’t need to be done. For example a patient comes in with a congestive heart failure and they give them an EKG two months ago this patient probably doesn’t need another cardiac testing but they are in the hospital. Since the hospitalists don’t know them that well they go ahead and they order another test. Overall, I think it comes down to communication. The pro’s of the hospitalist model is that you can communicate with the hospital staff better but the downfall is that you don’t know the patient and so you’re really relying either figuring it out or communication from the primary care physician.

**Question 7: How much communication is there between a hospitalist and PCP’s?**

In healthcare systems where they have an integrated health information exchange or electronic health records I think that’s solely where you are going to get the communication. The
hospitalist looks up the previous X-ray result, previous admission history, discharge and office notes from the primary care provider that works very well. Otherwise, you’re really relying on the patient to communicate information. So in places where you have a system of electronic health records it’s going to work better than in places that you don’t. I’m not a hospitalist or primary care provider but my sense is that most people end up in the emergency room and get admitted to the hospitalist service and they figure out how to communicate. This has been going on a long time and I’m not sure of this is in a bad way. I think hospitalists just need to be careful about what they are trying to change. For example, you don’t want to reorganize their care when they do have a qualified physician outside the hospital. They should really focus on what is the thing that brought them to the hospital, what needs to be fixed and what do I need to communicate back to the primary care providers.

*Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?*

Yeah, I’m not sure there are a lot of advantages. If done correctly, good communication will end up with better results. It will help the hospitalist know what to focus on when the patient is admitted and what’s been successful. Right now you’re really relying on the patient and some medical records and vice versa because it leaves the hospital and hospitalists at least in getting better in communicating information back to the primary care. In some smaller hospitals that are confined I think that works really well. The primary care providers have a good relationship with the hospitalists. The hospitalists know when to pick up the phone and talk to the primary care providers and reverse. This ultimately leads to a system of open communication. I think it’s harder in big academic institutions which attract patients from a large area and not sure of that patient’s whole medical history as an outpatient and therefore, you are relying on them. The disadvantage to the current communication system is that there is not enough information at all passed along from both parties.

*Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?*

The patients are best served by the hospitalist when they are able to take care of the acute problem that’s bringing the patient into the hospital. They are less effective when they are trying to figure out why care has not occurred as an outpatient. For example, the patient comes in and they have a history of diabetes and that’s not why they are admitted but they realize that the diabetes is there. So the hospitalist is now trying to figure out how should I change this within patient. I think that is an okay thing to do and give their expert input but they got to make sure that’s really communicated to the outpatient provider. They have to have a good grasp of what are the resources within the community. They should not make any changes that are not necessary especially if they don’t know the patients history.
**Question 10:** Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

I’m not 100% sure but I would think it is cost-effective if for no other reason they are employees of the hospital. Along with this the hospital can get feedback from this information and they have the real ability to incentivize or decentivize the hospitalists. For example, if you say your thirty day admission rate goes above x number you’re not going to get a bonus but I’m not sure if that’s actually done. The hospitalists focus on taking care of patients; acute needs and getting them back to their primary care provider. If I had to guess if the hospitalist will have better financial outcomes I would say yes.

*Side Question:* I know from the literature research the reason behind the hospitalist model was to decrease the length of stay and because of the costs. Do you think that’s been addressed well?

I don’t know. I can’t answer that. I think that it’s really hard to be an outpatient physician and know how to take care of diabetes, osteoporosis, back pains and all of the other things that a primary care has to know how to do and then be completely up to date on all the standards of care. My sense is that if the length of stay is being lowered than yes.

**Question 11:** Are there any additional questions or suggestions that you have for me?

No, not really. I think though ideally neither system is perfect whether you are doing the hospitalist or the older way but I do believe there is a changing trend towards hospitalist. If you are going to put the hospitalist model they need to make sure there is excellent communication with the primary care provider.

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**Physician #02:**

**Question 1:** What are the roles of the hospitalist in the healthcare system?

My idea of the role of the hospitalist is that they serve as the on-site focal person for all the care of the inpatient.

*Side Question:* Can you elaborate more on that or is that all you know.

They take care and manage all the care for the individual that doesn’t require a specialist input. They also coordinate with whatever specialists are needed.

**Question 2:** How have these roles changed over time?

Not in my mind at all. The role has stayed the same in terms of the concept and so on.

**Question 3:** How are these roles expected to change in the future?
I don’t see the roles of the hospitalists changing at all. It is a growing field in hospitals that are large enough to be able to afford a hospitalist. I think the physicians who benefit from having hospitalists are both primary practitioners who don’t want to take the time to make rounds at the hospital. Also now some don’t want to learn how to use the electronic medical records which are very difficult to learn from the most part. They don’t want to learn them because if you have a six doctor primary practice and you’re using it one week out of six and not even the whole week thus making the hospitalist valuable. For a specialist like myself I uses EMR but even though I use it every day there are many features of the inpatient system that I never touch literally. I prefer to write orders to the patients. This further means for me that I don’t have to do the admission, physical exam and the discharge summary. I don’t have to be concern about the fact that the kid has a headache and go see him because all of that is handled by the hospitalist.

**Question 4: What has been or will be driving these changes?**

Money. Money’s at the heart of it but for people again in outpatient settings like both primary care and specialists you don’t make money driving back and forth to the hospital. You make less money in particular if you only have one or two unless you’re an adult internist and you have twenty patients. This is not the case in pediatrics at least and even for the adult internist you have to be part of a large practice to have enough patients for it to be worth wild. I make much more money seeing an office full of patients than I do driving to the hospital. The other piece of this is that if I were doing all the care instead of by some specialty I am stepping outside of my expertise. Overall, it’s about the money, expertise and time.

**Question 5: How do hospitalists address the needs of their patients and outcomes?**

They are very effective in addressing their patient’s needs and in diagnosing them as well, but the patients I have in the hospital I am doing all the follow-up. I would like to think they do it effectively but I honestly don’t know. All that I need to know from the hospitalist is that the patient has gone home.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

All the things that I have said already which is that they take care of things that I either can’t or don’t want to take care of. In terms of the healthcare financial system it is a more fair structured because you’re now getting two physicians paid for the care instead of getting one and it is appropriate because the two physicians are handling two different aspects of the patients care. Disadvantage when you’re talking about the hospitalist to PCP relationship is the lost of continuity for the patient. Especially if you are dealing with a doctor and a hospitalists schedule you might run into two hospitalists in one day.

**Question 7: How much communication is their between a hospitalist and PCP’s?**
I have no idea. I would imagine not that much but with the electronic medical records the potential could be positive.

**Question 8:** What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?

I honestly don’t know how it works so that’s a real disadvantage because I’m not a PCP.

**Question 9:** Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?

Basically is the same answer that I gave you before. That is that they are very good at taking care all the general pediatric issues and they are not good at and try to take care of the specialist issues. The lines are usually pretty clear cut between the two.

**Question 10:** Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

I don’t know but I would imagine because the hospitals are trying to decrease the length of stay and costs it has to be. If it were not it would not have lasted as long as it has already. I don’t know the figures but I can imagine it has because you’re hiring a hospitalist on a salary instead of constantly having PCPs coming in and out each day. Overall, from my side of it, it is cost-efficient because I don’t have the time to do general pediatric management with inpatients. It has saved me a great deal of time not doing that.

**Question 11:** Are there any additional questions or suggestions that you have for me?

Well I will say to you that hospitalists serve a good purpose but they need to know there role sometimes because they overstep their boundaries trying to do the PCPs job. Again, I’m in favor of having them because they are beneficial to the patients, hospital staff, PCPs and the healthcare systems as well.

**Nurse Practitioner #01:**

**Question 1:** What are the roles of the hospitalist in the healthcare system?

It has been a while since I worked with hospitalists just to let you know. The hospitalists I have worked with have been in Atlantic City and from my understanding their roles are to take care of the patient’s while they are in the hospital. They also facilitate consultations.

**Question 2:** How have these roles changed over time?

Umm, there are more hospitalists and a lot more physicians working for hospitals as well. I don’t know if that is necessarily good, bad or indifferent. Physicians can’t afford practices or
hard to run an office in this day and age with reimbursement. I don’t know what’s causing the trend but I have seen more hospitalists.

Question 3: How are these roles expected to change in the future?

I think they are going to increase because everybody is going to work for a corporation to get their health benefits. Along with this I think you will see this because they would not have to pay for the overhead of the offices and so on. You can see an increase definitely because of job security as well.

Question 4: What has been or will be driving these changes?

I answered that. To get away from the office and less reimbursement. If you hear a rumor that a pediatrician makes seven dollars per patient that he sees, do you know how many patient’s you have to see per day to pay your staff.

Question 5: How do hospitalists address the needs of their patients and outcomes?

I think hospitalists look only at the presenting problem and I don’t think they look into the whole patient total. I think they look at the patient being in here for chest pain and let’s keep them on that line. When it comes to outcomes I think they are good at that and especially for that one particular need that the patient requires as well. Overall, that what they get paid to do. They are not paid to do the primary doctor’s job.

Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?

Advantage would be that the hospitalist knows how the system works and they know how to get the patient through to solve the problem. When their doctors come in they are aware of the patient and all the problems and they are able to address everything. A disadvantage is that they don’t know the patient at all. The hospitalist doesn’t know their background or history and so on.

Question 7: How much communication is their between a hospitalist and PCP’s?

I don’t know how much there is at all. I would say none but I really don’t know for sure.

Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?

Poor.

Side Question: What do you mean by Poor?
Like I said I don’t think there is any and there is no continuity there. They just want to get the patient out of the hospital. Hospitalists are supposed to shorten the length of stay of the patient inside the hospital. I see this as a disadvantage the communication part.

**Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?**

They are best served at decreasing the length of stay. They are less effective when it comes to looking at the whole patient as compared to just the problem. This would clearly be a disadvantage.

*Side Question: Why would you say hospitalists are less effective in that?*

They are less effective because they only look at the problem that the patient’s in the hospital for. For example, they look at the chest pain and not necessarily the blood sugars and other comorbidities as well.

**Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?**

They are there all the time. They see the patient in a timely fashion and sometimes if you’re waiting for the primary until the next day they will be able to expedite the care for the patient to get them out. This in turn is cost saving for any hospital based system.

**Question 11: Are there any additional questions or suggestions that you have for me?**

My last suggestion is to maybe look at where to throw in the residents and the teaching patient’s because that’s a whole new topic.

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**Nurse #01:**

**Question 1: What are the roles of the hospitalist in the healthcare system?**

It’s a hospital based practitioner that coordinates inpatient care. They pretty much look to me as almost navigators who know the hospital system well and can direct the patients where they need to go. They are essentially managing the hospital along with the patient because they have to go through departments and consults. It is different than an outsider who has to come in and doesn’t know the staff and so on.

**Question 2: How have these roles changed over time?**
I don’t necessarily think they have. From what I have seen they have remained the same and are essentially a coordinator of the patient care while they are admitted. It also seems like the hospitalists is becoming more of a predominant specialty to consider.

**Question 3: How are these roles expected to change in the future?**

I can tell you what our ideas are and that is to be less of them because they are following the resources and the money is in the hospital as opposed to the outside in the community. If we had it our way we would be routing because a lot of these folks specialize in internal medicine and they stay in the hospital because I feel that’s where the money opportunity is. There is two ways it can be expected to change. It sounds like more people are going to become hospitalists which is great in a hospital focus system. Then you can see more PCP’s as well go up if the residences decide to focus on that field more.

**Question 4: What has been or will be driving these changes?**

I think definitely the economics, right. Think about it where is the money going are we putting money into the hospital based medicine or what. If it is going to go on a different direction like we are trying to do. We are trying to route money into patient center medical homes. Overall, if money is routed there and there are opportunities there along with growth then folks will go there. So we have to look at where is the incentive.

**Question 5: How do hospitalists address the needs of their patients and outcomes?**

I think while the patients are admitted to their hospital they are effective and good at addressing their needs and the outcomes but the social needs such as housing and so on are not addressed at all. It is to be expected though because they are hospitalists and furthermore because they will give great instructions to a diabetic who will be discharge to the street and I feel it will a little difficult for that person to maintain. Medically they are very well meaning. They stabilize and manage diseases very well but when it comes to discharge especially in a city like Camden where there are a lot of high needs it is very poor. They do a great job in the hospital sometimes but if they have issues with mental health, addictions, homeless or poor then they get readmitted to that hospital again.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

An advantage for the hospitalist model is that there is continuity of care for the patient until they leave the hospital then the continuity is lost. A disadvantage is the built of trust or relationship between a patient and hospitalist. Overall, though I think both models work and it would seem like it would be up to the physician in how they would want to do it. Three advantages are definitely that the hospitalist is aware of the hospital system, they can coordinate between
specialties and you would have an advocate. A disadvantage is definitely that there is very little communication with the PCP’s or in other words there is a fraction of care.

Question 7: How much communication is their between a hospitalist and PCP’s?

It is practically non-existent. There is a letter that is faxed over and if you’re lucky it makes it to the patients chart and to the PCP. I have gone to multiple PCP appointments where their PCP’s had no idea that their patients were hospitalized and so on.

Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?

We deal with the lowest and poorest population of individuals so in my opinion they get the worst treatment in everything including when it comes to communication. I see as an advantage the communication system only if both parties are constantly communication via call, fax or EHR. A disadvantage can come when they cannot identify a PCP for that patient and then what happens. They can potentially fall of the crack and that’s a big issue.

Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?

They are best serve at doing what their job is and also in decreasing the length of stay as well as the costs. They are very effective in managing care and the diseases as well. They are less effective in addressing the social and psychological behavior of a patient’s family within the community. They are less effective also in communication.

Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

I think hospitalists are great and are excellent in providing inpatient hospital based medicine. If you look at the bigger picture it’s hard for me to say if they are cost-effective. If they follow protocols and do their checklist I guess they are. If they are good in decreasing the length of stay and the costs I would say so.

Question 11: Are there any additional questions or suggestions that you have for me?

I just feel the hospitalists need to look at the social and psychological factors because they tend to not acknowledge that aspect. There are many patients that get disservice because hospitalists don’t look at this issue. We see them a lot and it’s time for them to consider that as well.

Nurse #02:

Question 1: What are the roles of the hospitalist in the healthcare system?
They basically run and control all of the inpatient need. They regulate how the patients come in and seen in the appropriate units. Another part of their role is to keep in mind how quickly can we get them out and not get repeated admissions as well as are we getting paid. Overall, I see them as a navigator throughout the whole hospital.

**Question 2: How have these roles changed over time?**

I actually don’t know I was not a nursing major back then from 1996, my only experience has been from 2007 up to now and all I can say is that it has remained the same. The roles may have remained the same but they might have changed what they are doing.

**Question 3: How are these roles expected to change in the future?**

I think you will see more hospitalists for example we have had an increase in teams. When I first came we only had A-D but now we have up to HH teams. I also think more hospitals will have them as well.

**Question 4: What has been or will be driving these changes?**

I feel that certain teams should manage their own patients and maybe it will be more effective. For example, cardiology or neurology and if the patients primary issue is only that then you really should come under their service. If you come in with a heart problem you should be seeing by the cardiologist and period. The hospitalist should focus on the whole body in terms of comorbidities.

**Question 5: How do hospitalists address the needs of their patients and outcomes?**

I think they address the needs of their patients effectively and as far as outcomes they don’t address that sometimes at all. It’s hard to address those especially if the patient is not doing what they were told to do when they were first admitted in the hospital.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

I would prefer the hospitalist model because the hospitalists are always here and always ready for any situation. If you’re a primary physician who is sitting in the office when they go home they are not coming here in the night they will come back in the morning. A disadvantage would be the lack of trust almost. Some patients come in and would want to see their doctor even though they see a hospital based doctor. Another disadvantage would be communication but in terms of the lack of knowledge from the patient side. If you come in as a hospitalist you’re looking at a patient’s chart and your reading what it says and you will treat that patient just general.

**Question 7: How much communication is there between a hospitalist and PCP’s?**
I’m not sure. I don’t know if they necessarily always call the PCP. Usually we give the patient to follow up with their PCP and so on. Usually when they change the medications they doctor usually calls and leaves a message for him or her at the office but not all the time. Overall, I really don’t think there is at all.

**Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?**

I don’t really think there is a problem. I think there is an advantage when it comes to informing them unless they are not talking to them then that’s a different story. From my experience I think it’s an advantage that they do talk to them and discuss this individual’s care. I don’t see any disadvantages besides probably the PCP wants to treat their patient a certain way and the hospitalist is not to fond of that treatment or care.

**Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?**

As far as effectiveness I think they are effective in their individual areas in terms of seeing their patients and doing their part. I think they are less effective as a whole. For example, they may be good when it comes to looking the individual parts but as a whole they are not good at.

**Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?**

I don’t know because I don’t have anything to base it on. I would only assume so because the specialist would be charging more. I would also assume it would be economically better for the hospital to have a hospitalist rather than paying all these consulting groups.

**Question 11: Are there any additional questions or suggestions that you have for me?**

I think it would help me if I knew more about the hospitalist model because I was under the impression there was more than one hospitalist model. I thought there would be a flowchart or a diagram that would depict the hospitalist model I wasn’t sure until you explained it to me in question #6.

**Nurse #03:**

**Question 1: What are the roles of the hospitalist in the healthcare system?**

The way the work here is that they handle all the admitted patients and then they consult for specialties if it’s needed. They also further manage the patient as well and their goal is to manage the acute care and then get them out so that they can be seen in the community by their family practitioner or a specialist they need to follow up with.
Question 2: How have these roles changed over time?

I think that there has been a change. In fact it’s had to change because the role of everyone in the hospital has changed. The patients in the hospital are from acute delivery before therefore patients are being discharged while they are still acute as opposed to being sent home and managed at home sicker than back in 1996 when things first got started. I think the hospitalist have gotten to the point that now they are better in focusing at the acute issues. There has also been an increase in more hospitalists.

Question 3: How are these roles expected to change in the future?

I expect there to be more hospitalists in the future. I think that the hospitalist role is also going to get more comprehensive as well. The field will get bigger. Right now not every hospital has a hospitalist program. Some hospitals have hospitalist programs but not for every patient that comes in the door.

Side Question: Ok, and what do you attribute that to, meaning the hospital is not big enough.

No I think it’s still a matter of some outside providers who still want to maintain some control of their patients when they go into the hospital. So they are not willing to give that up and if there is enough of them together that can put a united front to the hospital then they are able to continue to maintain their patients.

Question 4: What has been or will be driving these changes?

I’ll guarantee it will be the payers meaning insurance companies. Along with them I would say most definitely financial as well because the hospitalist goal is to treat remedies and in the past the family practitioner who would see the patients from the hospital are not here all day long. All they do is come in and see their patients and go back to their office and do office hours and then return the next day and check on them again, whereas hospitalists are here 24/7 and they continue to monitor what is going on and push for more testing to get their patients out in a timely manner. By introducing more hospitalists and managing more of the patients care by the hospitalist as opposed to the general practitioner the length of stay should go down and reimbursement should be better and less fewer denials.

Question 5: How do hospitalists address the needs of their patients and outcomes?

They consult specialists, so if it’s a medical need they consult a specialist and then they follow their recommendations as to what needs to happen once the patient leaves. If it’s a social need the hospitalists are usually in tune with what social needs the patient needs and consult social worker or a case manager to help handle what needs to happen on the outside. A lot of the hospitals are very concerned about follow-up and the ability to follow-up. Furthermore, we
have many patients that come in without insurance so the goal is to find them a provider that will take them without insurance. As far as outcomes are concerned they don’t really follow-up with the patients once they leave, however, there are times when they order something to be done in here and the results may come back after they have been discharged leaving them to follow-up at that point. For example, if there are other test results that need follow up they will call them and get follow-up.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

The one disadvantage is that many times they don’t know the patient. I really think that’s the only disadvantage that I see because the other mild disadvantage is that they don’t follow-up with the patient. The advantages are that the patient does get more direct care, get a fast return of results when it comes to receiving tests results as soon as possible.

**Question 7: How much communication is their between a hospitalist and PCP’s?**

They communicate with the providers and even sometimes call them to let them know what’s going on with their patient inside the hospital. I think communications is good and at least here they do a very good job. One thing I want to point out is if the PCP is a hospital based provider they can access all their patient information as well. If they are not a hospital based provider they get the discharge summary and sometimes a phone call and they do this effectively.

**Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?**

If both providers are hospital based providers then the communication is a lot better that’s a big advantage. A big disadvantage is that our system doesn’t really get updated a lot so there may be times that the hospitalist will ask the patient is this the doctor you see on a regular basis and they also have a social worker come in as well and ask who their PCP is and we have had a couple of PCP’s that have retired and they are still listed as those patients PCP’s. Another disadvantage would be that you cannot get a hold of who you want to talk to if you’re trying to get direct information.

**Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?**

They are best served with any patients that come in with any kind of general medical condition or if they have any comorbidities. The reason is because they can manage the comorbidities, for example if someone comes in and they are complaining of lung pain and they have a cardiac and
GI history all those things need to be coordinated, and rather to put them on cardiac services and hope that they coordinate everything they will not. The reason they will not is because cardiologist will look at cardiology while the hospitalist will look at the whole person. Some areas where I don’t think they are less effective are in surgical patients. I think that if it’s a surgical patient it should be monitored by surgery and they can consult medicine to come in and see them to manage other medical conditions. The primary reason the patient comes in for is surgery then that’s who should follow them not a hospitalist.

*Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?*

Yes, in the three years that I have been here I know that our denial rate from the providers has gone down. We had a very high denial rate at one point and it’s based on how they handle the patients and their documentations along with moving the patients along faster and getting paid.

*Side Question: That’s, something new to me and I never heard of this term “denial rate.” Can you expand more on it.*

As a case manager we have to send out reviews to the HMO companies and they have to meet a certain criteria in order to be inpatient. For some we made the decisions but for others we don’t. The ones we sent out the reviews to will let us know if it’s appropriate based on them if the patient is classified as inpatient or treated outside. When I first came here the denial rate was fairly high where the insurers would say the patient needs to go and doesn’t need to be in the hospital. Our goal is to have the denial rate below 2% and we have been consistently below that and it was between 6-7%.

*Question 11: Are there any additional questions or suggestions that you have for me?*

I think that at this point the model changes constantly as it should in order to keep up with current trends and the current trends meaning the providers or payers because that’s how we make things work. Also making sure what they need to get on the outside is available. We can certainly say to the patient “I want you to do this and this and so on” but if those things are not available then this plan is not going to work and we have to make sure they have a safe discharge plan before they leave and the hospitalists are very good at doing that.

**Hospitalist #01:**

*Question 1: What are the roles of the hospitalist in the healthcare system?*

The hospitalists role in a hospital setting revolves around three things. The first is patient care in terms of inpatient hospitalized care. The other role depends on the size of the hospital, whether
it is an academic health center or a community health center because these hospitalists can be teaching residents and medical students all depending on where they are. The third role is administration, in terms of helping the hospital to do some administrative work by doing some quality improvement performance things.

**Question 2: How have these roles changed over time?**

Has the role changed or evolved I would say, yes. I think it has evolved a little bit over the years. The initial focus was only length of stay and that was it. Plus, the definition of hospitalist over the year has changed as well. There were a lot of theoretical models and there are people who do 30% inpatient care or what they used to call hospitalists. I believe there are also multiple types of models of hospitalists as well. There are people within these models who work one week and of another week, now we have nocturnes hospitalists who only work at night. So the role has been different for a hospitalists, but the one role which has always remained the same is taking care of inpatient hospitalized patient effectively, efficiently and to get them out within the right frame of time. By doing this we are decreasing the length of stay and this was the ultimate initial goal. Now, I think they are getting more involved in more of the processes of the hospital like a JACO, performance improvement and goal measures of let’s say pneumonia. So, overall there role is getting into some of these quality indicators that has been decided by the government, medicare or insurances. My role now has been as an educator in education of hospitalists. The primary role has always been to be a hospitalist but now I do a lot of education and administration and not necessarily the hospital administration.

**Question 3: How are these roles expected to change in the future?**

I honestly don’t know. In America almost everything is market driven. It is all demand and supply. Currently the way it is working everyone thinks that hospitalist is the right thing to do for inpatient hospitalized patient. With this said there is an increasing need for hospitalists. I think you will see more and more younger doctors coming out from residency and going into hospitalists. There is a little bit of increasing and salary as well. At least for now you will see some growth but I think it will eventually settle down.

**Question 4: What has been or will be driving these changes?**

Most of the drivers in this country I think are economic drivers. I would say financial.

*Side Question: Can you expand on what you mean with financial.*

If the hospital reimbursement more specifically inpatient reimbursement is based on how they take care of the patient, for example the 30 day readmission by Medicare, right. So Medicare says if you admit someone within 30 days then we might not pay for a second readmission. So now they are going to look and make sure the hospital takes care of these people very well so this patient doesn’t come back again. So there are indicators and pressure coming from
insurance, Medicare or Medicaid that drives how you will manage the patient and that in turn will drive the hospitalist in how they will do their job. I think the financial driver. Overall, there are two drivers: one is the financial driver and the other one is quality driver for example if the people demand a quality indicator. I think those two are the main drivers that drive the hospitalists.

**Question 5: How do hospitalists address the needs of their patients and outcomes?**

I think there is a positive side and a negative side. The problem with hospitalists is that many times they don’t have any credible information and that’s a real problem. The amount of information that has been passed on from the outpatient to the doctor’s office to the hospitalist is sometimes not adequate or not appropriately transferred. I don’t know for whatever reason, either the lack of electronic medical records or the lack of communication. This then leads to the hospitalist either provide care, duplicate the care or use more resources when they don’t have anything. So fifteen years ago, it used to be the same doctor that use to see the same patient in outpatient and he will come and visit him as an inpatient and as a result of this people thought that model was not cost effective. They further thought the doctor used to keep the patient in the hospital longer but the downside is the same. Now we are not adequately communicating enough information and as a result we are using more tests. One issue of this decrease length of stay which is a big thing is when you try to do a lot in a little bit of time you end up ordering more tests because you want to get it done fast. Think about this the number of admissions has gone up even though the length of stay has gone down because the resource utilization has gone up.

**Question 6: What are the advantages and disadvantages of having the hospitalist model over the traditional models of healthcare delivery?**

I think is all about efficiency. As you said when the patient length of stay will be instead of seven days now five days, so this is one advantage. The patient in the hospital is seeing by the hospitalist more so I think there is more continuity in terms of care and quality. As far as disadvantages there is a big one which I said is information. In other words patient related information is not transmitted appropriately. Even if the information gets transferred it takes time and sometimes not all the information gets transferred at all. Another big disadvantage is the lack of communication between the hospitalist and PCP’s. There is not enough of passing information of appropriately health of care to PCP to the hospital and the consultant and from hospital to the consultant and so on. This overall can go well or not depending on the PCP and hospitalist.

**Question 7: How much communication is their between a hospitalist and PCP’s?**

I think people are relying on electronic medical records (EMR) for example if my patient is here at hospital A and their PCP is in hospital A then they can have access to the chart through the
computer. However, if the PCP is not part of hospital A or doesn’t have the EMR then that’s were the problem of communication comes in.

Question 8: What do you see as advantages and disadvantages of the current communication system between hospitalists and PCP’s?

Well like I said, if they are both within the system the advantage will be that effective communication should go well. If they are not within the system we do have some back up where we send them a discharge fax information to the doctor. If they are not both within the system the disadvantage will be that the communication might not be as well.

Question 9: Which areas of responsibility do hospitalists appear to be best served at your hospital as well as areas in which they are less effective and why?

I think they are used very effectively now for observation units like clinical decision unit where a patient was suppose to be not get a readmitted to the hospital. I think hospitalists are doing a good job there. I think they are effective in maintain the goal measures of quality indicators such as pneumonia. As far as less effective I think most probably the communication with the outside doctors.

Question 10: Do you think having a hospitalist in your hospital has proven to be cost-effective? If so, how?

I don’t know the data so I cannot answer that, but I’m pretty sure the hospitalist model is cost-effective. I think the saving of cost for the hospital is a soft dollar which is not used. In other words, if you are decreasing the length of stay you are decreasing the cost. They end up doing 15,000 dollars worth of work in 3 days compared to 5 days. There is no real data out there to suggest if it is but rather just people’s opinion.

Question 11: Are there any additional questions or suggestions that you have for me?

I think you are doing a good job but like you said this is a newly emerging field, so I think there is a lot of buzz there. Within this buzz you sometimes miss the real meat and I think you might want to talk to more people and get real meat. If you want to enhance your study you might want to interview 3 or 4 patients who are under the care of a hospitalist.

APPENDIX C: BAR GRAPHS
Percentage of Both Terms Coded by Staff Members

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Social Worker #2</th>
<th>Physician #2</th>
<th>Social Worker #1</th>
<th>Social Worker #3</th>
<th>Hospitalist #1</th>
<th>Nurse #3</th>
<th>Physician #1</th>
<th>Nurse</th>
<th>Practitioner #1</th>
<th>Nurse #1</th>
<th>Nurse #2</th>
</tr>
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</table>

FIGURE 3

APPENDIX D: IRB APPROVAL LETTER
MEMORANDUM

TO: Dennis Gallagher, MA MPA

FROM: Sreekant Murthy, Ph.D.
Vice Provost of Research Compliance

SUBJECT: Protocol - The Role of Hospitalists in Healthcare
Sponsor: Internal
Univ. Protocol No.: 1201000740

DATE: January 18, 2012

The subject study was reviewed by the Office of Regulatory Research Compliance. Per our review, the study proposes a survey/interview process with hospital staff to discuss their opinion regarding effectiveness of use of a hospitalist care model. This will be accomplished by developing an analysis of how, and to what extent, the hospitalist system is employed in the Philadelphia healthcare system, developing recommendations for improved communications between hospitalists and PCPs and developing an analysis of the cost effectiveness of the hospitalist model. The study involves no human interaction or intervention. Hence, the study is considered non-human subject research.

If you have any further questions on this, please feel free to contact me at 215-266-7887.