SAINT JOSEPH
Regional Medical Center

Version #: 6

Title: Hospitalist and Community Provider Service Agreement Medical Staff Policy

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Location: Saint Joseph Regional Medical Center (SJRMC); Mishawaka and Plymouth		Department: Medical Staff Services (14001_80012), Plymouth-Medical Staff Affairs

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POLICY/PROCEDURE:

Medical Staff Members who wish to participate with the Hospitalist Program will enter into a contractual agreement with the Hospitalist Program. Participants will choose to have the hospitalists admit all of their adult patients (established patients and unassigned patients) or only their "unassigned" or Emergency Department call patients. Participants will be obligated to provide for follow up care after discharge for these patients. The Hospitalist Program will communicate the pertinent details regarding hospitalizations back to the established primary care and specialist physicians.

Continuity and coordination of care is a high priority for Saint Joseph Health System and the Medical Staff. Therefore, the hospitalist program will provide timely discharge information to ambulatory care physicians, arrange for or request follow up care appointments for discharged patients, and assure that patients are returned to their primary physician of record. In addition it will be strongly encouraged that each PCP participating with the hospitalist program enters into the attached care coordination agreement (addendum A) and is cooperative with obtaining access to the hospital EHR system to facilitate a consistent line of clinical communication. This agreement will be presented to the participating PCP's upon the initial agreement and at reappointment if such an agreement has not been previously entered into. Entry into this agreement is strongly encouraged to facilitate safe, seamless patient care and collegiality. SJHS Hospitalist Agreement for the Coordination of Patient Care (attached)

"Unassigned" patients who are admitted by a hospitalist will be assigned to a participating physician in the community on the day of admission for potential follow up care. This assignment will be based on the patient's chronic medical conditions and presenting problems and will be facilitated by the Emergency Department Attending according to the Emergency Department Call Schedule. The assigned physician will receive information about the hospital course at the time of discharge and he or she is expected to accept the patient for follow-up care as a condition of participation with the Hospitalist Program. The SJHS Family Medicine Residency service will have access to "unassigned" patients on a case-by-case basis, as well, based upon census of service.

If a participating primary care physician sends an established patient to the hospital for admission, the hospitalist will do the history and physical exam. Participating physicians are welcome to make "social rounds" on their patients but cannot submit a hospital care charge while the attending physician is a hospitalist.

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Providers choosing to participate in the program will be able to choose to turn over all of their adult patients to the Hospitalist Program (established patients and unassigned patients) or, only their unassigned patients. Providers who typically maintain the care of their adult in-patients are welcome to contact the Hospitalist service to pre-arrange care for their patients when out of town or otherwise unavailable. Notification of the Hospitalist service prior to the requested coverage is essential and required.

For patients who have a primary care physician participating with the Hospitalist Program, specialty consultations will be ordered according to the established referral patterns of the primary care physician. If a patient does not have a primary care physician, specialty consultants should be chosen according to the Emergency Department On-Call Roster at the time the consultation is needed. All consultants should be notified of a consultation request according to Medical Staff Rules and Regulations. Physician to physician communication is preferred in all cases according to Medical Staff Rules and Regulations.

Patients who are admitted by the Hospitalist Program will be informed about the purpose of the service and its potential benefits. They will be reassured that their established ambulatory care specialists and primary care physicians will be informed about their hospital course and outcomes. Patient satisfaction will be monitored with surveys generated by Saint Joseph Health System, Sound Physicians (Mishawaka) and Midwest Hospitalists (Plymouth) (contracted to provide the Hospitalist Service), and the federally sponsored Hospital Consumers' Assessment of Healthcare Providers and Systems (HCAHPS).

The Hospitalist Program will assure successful communication regarding the details of hospitalizations with primary care and ambulatory care specialist physicians. This will include the discharge summary, pertinent diagnostic test results, and the discharge medication list. Participating physician satisfaction regarding the success of the Hospitalist Program will also be surveyed by Saint Joseph Health System.

References/Standards:

- Policy Origin Date: November 2019
- Review Date: December 2019
- Revised Date:
- Effective Date: December 2019
- Reviewed/Recommended By: Medical Executive Committee
- Policy 227

Saint Joseph Health System

Based upon Hospitalist and Community Provider Service Agreement Policy

AGREEMENT FOR THE COORDINATION OF PATIENT CARE

In the interest of improving communication between the Primary Care Physicians of our community and the Hospitalist Inpatient Care Team at Saint Joseph Health System, an agreement between Saint Joseph Health System and it's contracted hospitalist physician group (hereafter referred to as HCT) and Dr._____ (hereafter referred to as PCP) do jointly enter into this Care Coordination Agreement with the intention of defining the roles of each party to maximize communication and coordination of Patient Care.

Article 1: Communication Procedures

Communication between parties shall occur in full compliance with relevant hospital policies and applicable state and federal laws regarding patient privacy and confidentiality. Communication methodology which may be utilized includes direct phone contact, Doc Halo (a secure HIPPA compliant text messaging system) Secured Email or Fax. The primary general contact number for contacting the HCT is 574-_____. The Medical Staff Office maintains and publishes a list of contact information for each member of the HCT and of each primary care physician which includes preferred and alternate methods of contact as appropriate. It is expected that at a minimum, communication about a patient visit will occur at the time of admission, at the time of discharge and at any point during the course of hospitalization where decisions are being made that will have significant impact beyond the hospital visit.

Article 2: Responsibilities of the Parties at the Time of Admission

It is recognized that multiple pathways exist for patients to be admitted into the hospital and therefore recognized that each situation may be unique. In general, patients will either be admitted directly from the PCP or via the emergency room after appropriate workup by the ER medical staff. In the case of direct admission by the PCP, the PCP will:

- Discuss the case with the Hospital Care Team (HCT) member on duty in preparation for admission.
- Provide demographics:
  - Patient name, DOB, and contact information
  - Contact person if not the patient e.g. healthcare proxy or guardian
  - Any special considerations, such as vision/hearing impairment, cognitive deficits, language/cultural preferences
  - PCP contact information
- Provide the reason for hospitalization:
  - Primary complaint /medical issue/assessment and diagnosis
  - Key physical findings and/or test results and a summary of recent changes in status
  - Any co-morbid conditions that will need addressed during hospitalization
- Prepare patient/family/caregiver:
  - Ensure understanding of reason and agreement with planned hospitalization
  - Ensure safe transfer to the appropriate facility in manner that takes into account

patient preferences
- Provide hospital contact information and expected time frame for hospital length of stay

In the case of patients being admitted to the hospital via the ED that are under the care of the PCP, the HCT will:

- Notify the PCP of admission.
- Communicate with the patient/family/caregiver the purpose/expectations and goals of the hospital stay and ensure understanding.
- Establish communication with the PCP that addresses transfer of pertinent patient clinical information at admission, during hospitalization and at discharge.
- Validate a means of contact for routine and urgent situations which may occur during the course of the admission.
- Obtain and review pertinent medical information from the PCP.

In the case of patients being admitted to the hospital via the ED, upon being notified by the HCT of the admission, the PCP will:

- Provide appropriate and adequate information to the HCT in a timely manner. If known, this information should include:
  - Problem list
  - Current list of medications
  - Current list of allergies/contraindications
  - Relevant medical and surgical history
  - Any Advanced directives
  - Any additional information specifically requested by a member of the hospital care team.
  - PCP contact information during routine and urgent situations.

Article 3: Responsibilities of the Parties During the Hospital Stay

During the hospital stay, the PCP will:

- Respond to all incoming calls or other communications from HCT in a timely manner.
- Engage with HCT around significant clinical issues arising in the hospital that will extend beyond the hospital stay.

During the hospital stay, the HCT will:

- Keep the PCP notified of major clinical developments.
- Involve the PCP as needed in significant patient care decisions that will have a significant impact post discharge, i.e. care transitions.
- Assure that the patient and or caregiver/proxy is kept fully informed regarding diagnosis, test results, and treatment options as appropriate.

Article 4: Responsibilities of the parties at discharge

When the patient is ready for discharge, the HCT will:

- Inform the patient/family/caregiver of diagnosis, prognosis and follow-up recommendations and ensure understanding.
- Inform the PCP of the pending discharge from acute care.
- Provide educational materials and resources to patient as appropriate.
- Provide a reconciled medication list and any scheduled appointments.
- Advise patient/family/caregiver of any outstanding tests that will require follow-up by their PCP.
- Work to ensure that patient/family/caregiver are in agreement with discharge plans.
- Provide information on how to manage symptoms and how to identify those requiring immediate medical attention and the contact information for appropriate providers.
- Transmit a discharge notification to the PCP which will include a concise discharge summary:
    - Reason for hospitalization
    - Summary of results of all testing/procedures
    - Discharge diagnosis
    - Current medication list
    - Pending studies
    - Patient instructions
- Make follow-up appointments with PCP if appropriate and necessary.
- Receive calls from PCP as needed for additional information or clarification.

Upon discharge, the PCP will:

- Engage in collaborative care management:
    - Around transitional care planning
    - Ensure receipt of discharge notification
    - Resume care of patient
        - Review patient Information upon discharge from hospital setting.
        - Agree to make contact with the patient within <u>two</u> business days of discharge.
        - Arrange clinically appropriate patient-centered appointment time.
        - Assume responsibility for follow up of pending results and/or scheduling recommended testing for diagnosis and/or medication monitoring.
        - Reach out to HCT if issues arise post-discharge that require input from that team.

Signed _____ Date _____
Referring Provider

Signed_____ Date _____
Hospitalist Representative