PATIENT SATISFACTION WITH COMMUNICATION FROM HOSPITALISTS IN AN ACUTE CARE SETTING

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ABSTRACT

Patient Satisfaction with Communication

from Hospitalists

in an Acute Care Setting

Doctor of Medical Humanities Dissertation by

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Background: As the use of hospitalists increases, health care reimbursement is transitioning from a fee-for-service model to a quality-of-care model, and patient satisfaction with communication is a priority. There has been little research assessing factors associated with patient satisfaction with hospitalist communication.

Objective: This study examined demographic and clinical factors related to patient satisfaction with communication with a hospitalist team in an acute care setting.

Methods: This study of 75 patients was conducted at a not-for-profit, level 1 regional trauma center in northern New Jersey. The association between demographic characteristics (gender, age, and ethnicity) and clinical characteristics (length of stay (LOS), primary care provider (PCP) relationship, number of hospitalists seen, and diagnostic group) and patient satisfaction with communication were examined. Patient satisfaction with communication from hospitalists was measured using a communication assessment tool (CAT-T). The Kruskal-Wallis test was used to identify differences in median CAT-T scores by demographic and clinical factors. A multivariate linear regression model was performed to examine the contribution of each of the independent variables to CAT-T score. A Mann-Whitney U-test was applied to further analyze

satisfaction with communication and LOS. To assess the association between satisfaction with communication and satisfaction with medical care, a Pearson correlation was computed.

Results: Demographic variables did not contribute to patient satisfaction with hospitalist communication. There were no significant differences in communication satisfaction based on whether patients had a PCP or the number of hospitalists with whom there was communication. A multivariate regression analysis was utilized to examine the contribution of the demographic and clinical variables to the CAT-T total score. The only significant predictor of satisfaction in the regression analysis was diagnostic category. Individuals with surgical diagnoses (n = 17) reported less satisfaction with communication than those with medical diagnoses. There was a significant difference by LOS, with patients with longer lengths of stay being more satisfied. There was a positive linear relationship between satisfaction with communication and satisfaction with medical care ($r = 0.863$, $p<0.001$).

Conclusions: Based on the results of this study, patients seem satisfied with hospitalist care. Because a shorter LOS was related to overall fewer excellent interactions with communication from hospitalists, clinicians should focus on establishing rapport early in the hospital stay.

Keywords: patient satisfaction, hospitalist, doctor-patient communication

To Bruce, Derek, and Robert,

You are my world.

For my parents, Ed and Mary Ross,

Thank you for making me the person that I am.

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LIST OF ABBREVIATIONS

ABMS	American Board of Medical Specialties
AHA	American Hospital Association
CMS	Centers of Medicare and Medicaid Services
EMR	Electronic Medical Record
ER	Emergency Room
GME	Graduate Medical Education
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
JC	Joint Commission
LOS	Length of stay
NP	Nurse Practitioner
NPSG	National Patient Safety Goals
PA	Physician Assistant
PCP	Primary Care Provider
PI	Principal Investigator
SHM	Society of Hospital Medicine

Chapter One

Introduction

The very first requirement in a hospital is that it should do the sick no harm.
—— Florence Nightingale

Acute care hospitals have undergone a radical shift in care delivery, resulting in a frequently confusing and frightening environment for patients and families. The creation of the hospitalist model has added another layer of care to an already complex system. In the hospital, failure to communicate effectively can have devastating consequences, such as medication and surgical errors, as well as a loss of trust in medical professionals.[1] The therapeutic relationship between patients and physicians is grounded in clear, unambiguous communication. This study is being conducted to evaluate hospitalists' communication with patients in the acute care setting. The identification of communication deficiencies can guide interventions to promote effective communication, which can enhance patient satisfaction and care.

Communication is at the forefront of health care discussions. The U.S. Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ) promotes initiatives, which support health care providers and patients to engage in effective communication to safeguard care and improve health-related

[1] Institute of Medicine, "To Err is Human: Building a Safer Health System," Report Brief, November 1999, 2. http://www.iom.edu/reports/1999/to-err-is-human-building-a-safer-health-system.aspx (accessed March 17, 2015).

outcomes.[2] In addition, the Institute of Medicine report, *Dying in America*, emphasizes the importance of health care providers having open communication with patients regarding end-of-life wishes and health care goals.[3] The importance of clinicians improving their communication skills is evident and strategies need to be in place to promote communication skills.[4]

As it relates to patient care, the tenets of good communication cannot be overstated. Most patients have a hospitalist assigned to their care at the time of hospital admission. An evaluation of patients' perceptions of the communication skills of hospitalists can provide important data, which can be used to further improve care and enhance patient satisfaction. This descriptive study will provide evidence to support the importance of effective communication by hospitalists when they are providing care to acutely ill patients with whom they have established a relationship.

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[2]The Agency for Healthcare Research and Quality, http://archive.ahrq.gov/news/newsroom/press-releases/2011/questions.html (accessed March 17, 2015).

[3] Institute of Medicine, "*Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of -Life,"* Report Brief, September 2014, 2 - 3. http://iom.edu/Global/Search.aspx?q=dying+in+ameria&output=xml_no_dtd&client=iom_frontend&site=iom&proxyreload=1 (accessed March 17, 2015).

[4] Institute of Medicine, "*Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of -Life,"* Report Brief, September 2014, 2 - 3. http://iom.edu/Global/Search.aspx?q=dying+in+ameria&output=xml_no_dtd&client=iom_frontend&site=iom&proxyreload=1 (accessed March 17, 2015).

Hospitals and History of Hospitalist Medicine

Hospitals are an important, integral part of the health care system. The American Hospital Association (AHA) represents and serves all types of hospitals, health care networks, and their patients and communities. The AHA, founded in 1899, provides education for health care leaders and is a source of information on health care issues and trends.[5] On its website the AHA explains that hospitals serve many functions. Hospitals are

- Economic contributors. Hospitals employ more than 5 million people, making them American's second largest source of private-sector jobs.
- Gateways to care. Hospitals serve every type of community: urban, rural, large and small. They are constantly working to improve access to care for all patients from newborns to seniors.
- Centers of innovation. Hospitals bring the latest medical innovation and technology to patients, providing highly specialized health care.
- Improving community health. The mission of a hospital goes beyond treating illness. Hospitals strengthen communities by working not just to mend bodies, but to make people and communities healthier.
- Committed to quality and safety. Hospitals are dedicated to improving patient quality and safety in every community.[6]

Hospitals house advanced technologies that deliver quality, high-end treatments. Stable patients may seek treatment at hospitals as outpatients and return home after the delivered therapy. Less stable patients, or those receiving care permitted only in the monitored hospital environment, remain overnight and are referred to as inpatients.

[5] Information obtained from the American Hospital Association website at www.aha.org. The AHA vision is of a society of healthy communities, where all individuals reach their highest potential for health. Their mission is to advance the health of individuals and communities. The AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement (accessed October 28, 2014).

[6] American Hospital Association, http://www.aha.org/advocacy-issues/initiatives/hosp-story-index.shtml (accessed October 28, 2014).

Hospitals employ individuals such as physicians, nurses, pharmacists, and technicians to provide around-the-clock care to this population of patients.

Evolution of the Delivery of Care

Hospitals, also known as acute or tertiary care facilities, deliver care to patients in many different ways. The traditional method of delivery occurs when primary care providers (PCPs) admit patients to the hospital and manage medical care during the acute illness from presentation through discharge from the facility. For example, a patient is not feeling well and subsequently calls his/her PCP for an appointment. After the patient is seen and examined in the office, the PCP recommends admission to the hospital; then he or she directs, manages, and coordinates the care of the patient until discharge.

Dr. Robert Wachter organized hospital care into four stages.[7] The first stage is the historical, most familiar method of delivering care, wherein PCPs manage the care of their own patients during the hospital stay. An advantage of this stage is the maintenance of continuity in care. However, PCPs may be overwhelmed by providing care to patients seen in the office, while simultaneously overseeing acutely ill patients in the hospital. Stage 2 involves members of a physician practice sharing visits to hospitalized patients on a rotational schedule. This method of "making rounds" provides patients with a link to the PCP's office, and they may even see their PCP if the rotation schedule coincides with their hospital admission. Voluntary hospitalist usage is Stage 3. PCPs may choose to use a hospitalist to manage the care of their patients while they are in the hospital. In

[7] Robert M. Wachter, "The Evolution of the Hospitalist Model in the United States," *The Medical Clinics of North America* 86 (July 2002): 691-695.

this stage, PCPs are no longer practicing in the acute care setting. They may begin to lose their expertise in acute medical management. Stage 4 comprises mandatory use of hospitalists. Support from hospital administrators and PCPs is needed for a successful mandatory hospitalist model of care. Wachter reports that each stage has its advantages and disadvantages. Not all will meet the needs of all hospitals or all patients and PCPs, and there will be variability in implementing hospitalist care.[8]

Health care delivery began to change with the implementation of managed care in the 1940's. It continued to evolve into systems that included health maintenance organizations (HMOs) and preferred provider organizations (PPOs). These changes altered how consumers obtain health care services. Hospitals consolidated and physicians moved away from solo practices and joined practice groups to function more cost-effectively.[9] In addition, advances in medical science supplied hospitals with more sophisticated therapies. Dedicated physicians needed to manage and care for patients in this high-level dynamic environment. Wachter states,

> In the 1990s, a competitive market for health care emerged in the United States, one in which patients and purchasers began to seek out less expensive (and high quality) care delivery systems. These pressures to more efficiently use hospital resources, coupled with new technologies and organizational innovations that displaced a significant amount of hospital care to ambulatory and short-stay environments, prompted a rethinking of the organization of inpatient care in the United States.[10]

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[8] Wachter, 691-695.

[9] Peter R. Kongstvedt, *Essentials of Managed Health Care, 6th Ed.* (Massachusetts: Jones and Bartlett Learning, 2013), 3-11.

[10] Wachter, 687.

These changes led to a new delivery of care model known as the hospitalist model of care. The specialist known as the "hospitalist" is now an active professional rendering medical care to patients in hospitals.

Reasons for growth in hospitalist medicine can be associated with time constraints placed on PCPs as well as diminished reimbursement from insurance companies. Managed care companies have demanded more patient appointments per day from their participating physicians. To meet financial targets, in practice one patient is seen every 15 minutes in PCP offices. Further complicating matters may be the commuting time between PCP offices and hospitals. These changes have led to a decrease in time that PCPs have to perform rounds in the hospital for their acutely ill patients. Some PCPs embraced the hospitalist model of care because it relieved them of hospital responsibilities and permitted them more time for management of private office patients. Hospitalist medicine assisted PCPs in meeting the additional responsibilities of their offices.

As well as providing PCPs with additional time to manage their office patients, hospitalist medicine has been shown to reduce costs.[11] Decreasing the spiraling costs of health care delivery is an important factor in the success of hospitalist medicine. The difficult fiscal times experienced by hospitals nationally have been well publicized. Thus, the financial benefits of the hospitalist model of care cannot go unnoticed. The

[11] Thomas E. Baudendistel and Robert M. Wachter, "The Evolution of the Hospitalist Movement in the USA," *Clinical Medicine* 2, no. 4 (July/August 2002): 327.

delivery of cost- effective quality care to patients by hospitalists has been duplicated and practiced throughout many health care systems.[12]

There are many private practices where patients are not always able to see one particular physician because the physician is part of a group. The patient may see any member of the group, although frequently one physician functions as the patient's PCP. The same may be true within the hospitalist model of care, depending on how the practice is arranged. One primary provider from the hospitalist group may oversee the care of a specific patient, but that provider is part of a team of hospitalists and any member of the hospitalist team may see the patient during the hospital admission to ensure comprehensive coverage.

This layered approach can cause confusion and concern for patients and their families because of the lack of consistency. Patients who respect and honor the doctor-patient relationship may believe that the relationship has been compromised by this situation. This perception needs to be addressed by both hospitalists and PCPs. In the hospitalist model of care, the relationship with PCPs will resume after discharge from the hospital. With thorough and complete communication, whether verbal or written, a transition from hospital care to outpatient care can occur successfully and the PCP-patient relationship restored.

It is important to note that many people do not have a PCP, nor do they see a physician regularly. This may be due to lack of insurance, good health, or avoidance of

[12] Kheng Hock Lee, "The Hospitalist Movement – A Complex Adaptive Response to Fragmentation of Care in Hospitals," *Annals Academy of Medicine* 37, no. 2 (February 2008): 145.

medical care in general. This group of patients may be indifferent to the hospitalist model of care because they lack a relationship with a dedicated practitioner.

The hospitalist model of care demands that communication among patients, hospitalists, and PCPs be continuous and complete not only throughout a hospitalization, but most importantly, at the time of discharge when care is resumed by PCPs. Whether one hospitalist or a team of hospitalists manages care, effective communication with patients is essential and patients' satisfaction with this communication is a priority for health care facilities and regulatory agencies.

Hospitalists: Who are They?

The inception of hospitalist medicine has been documented as early as 1996. Wachter provided a definition of the term:

> A hospitalist is a physician who spends at least 25% of his or her professional time serving as the physician of record for inpatients, during which time he or she accepts "hand-offs" of hospitalized patients from primary care providers, returning the patients to their primary care providers at the time of hospital discharge.[13]

Hospitalists have been providing specialized care for nearly two decades. Dr. Robert Wachter, along with Dr. Lee Goldman, created and published the term "hospitalist" in 1996, in their article in the *New England Journal of Medicine.*[14] The physicians argued that "realities of managed care and its emphasis on efficiency have

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[13] Robert M. Wachter, "An Introduction to the Hospitalist Model," *Annals of Internal Medicine 130* (February 16, 1999): 339.

[14] Robert Wachter and Lee Goldman, "The Emerging Role of 'Hospitalists' in the American HealthCare System," *The New England Journal of Medicine* 335 (August 15, 1996): 514.

promoted the growth of a new breed of physicians we call hospitalists."[15] They surmised that the hospitalists would provide care to hospitalized patients just as PCPs provide care in the outpatient setting.[16] Then, at the time of discharge, patient care would be handed back to PCPs or an outpatient clinic as indicated.[17]

A hospitalist typically has residency training in general internal medicine, general pediatrics, or family practice, and is trained to manage complex medical conditions.[18] Hospitalists do not see patients outside of the hospital setting because the care of patients is transitioned back to PCPs at the time of discharge.

Hospitalists have both clinical and nonclinical components to their role. Their clinical activities include providing the general medical care of hospitalized patients, medical consultations, co-management of surgical patients, critical care coverage, rapid-response or emergency coverage, ordering medications and treatments, and palliative care.[19] Non-clinical activities consist of membership on hospital committees (quality improvement initiatives, safety, pharmacy and therapeutics, utilization review, and information technology), teaching, and research.[20] Hospitalists provide a hands-on perspective and offer clinical expertise to these committees.

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[15] Wachter and Goldman, 514.

[16] Wachter and Goldman, 514.

[17] Robert Wachter, Lee Goldman, and Harry Hollander, *Hospital Medicine* (Philadelphia: Lippincott Williams & Wilkins, 2000), 3.

[18] The Society of Hospital Medicine (SHM), http://www.hospitalmedicine.org (accessed April 19, 2014).

[19] Kevin J. O'Leary and Mark V. Williams, "The Evolution and Future of Hospital Medicine," *Mount Sinai Journal of Medicine* 75, no. 5 (October 2008): 419.

[20] O'Leary and Williams, 419.

The number of physicians, physician assistants, and nurse practitioners specializing in hospitalist medicine continues to grow. The Society of Hospital Medicine (SHM) estimates that there are 44,000 hospitalists.[21] The increase in the hospitalist specialty is driven by economic factors and office-based demands of PCPs.[22] The result is that the number of hospitalists is increasing and their impact on health care is continuing to expand.

The SHM was founded in 2003 to meet the needs of the growing numbers of physicians providing care only in the acute care setting. With the increase in hospitalists, the need for a professional organization to support their beliefs and values and to help define their roles arose. The SHM promotes education and quality initiatives for their members. It supports hospitalists and claims, "to ensure the delivery of patient care, the development of research and the implementation of policies that reflect the highest standard of ethics in medicine. The society has an Ethics Committee to formulate and uphold high standards for the organization and its members."[23]

The SHM offers its own definition of hospitalists: "A physician who specializes in the practice of hospital medicine. Following medical school, hospitalists typically undergo residency training in general internal medicine, general pediatrics, or family

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[21] SHM, http://www.hospitalmedicine.org/Web/About_SHM/Industry/shm_History.aspx (accessed March 18, 2015).

[22] David R. Goldman, "The Hospitalist Movement in the United States: What Does It Mean for Internists?" Annals of Internal Medicine 130, no. 4 (February 16, 1999): 326-327.

[23] SHM, http://www.hospitalmedicine.org (accessed April 19, 2014).

practice, but may also receive training in other medical disciplines."[24] In addition to residency training, fellowships are available for physicians who want to achieve advanced expertise in hospital medicine. The SHM further defines the additional responsibilities and duties of hospitalists:

- attend to all patient care needs including diagnosis and treatment
- employ quality and process improvement techniques
- collaborate, communicate, and coordinate with all physicians and health care personnel caring for hospitalized patients
- safe transition of patient care within the hospital as well as from the hospital to the community[25]

The SHM provides hospitalists with guidelines for delivering safe and ethical healthcare, and supports the specialty so that it can provide the highest standard of medical care and continue to meet the needs of both hospitals and patients.[26]

Although most sources refer only to the physician as a hospitalist, physician assistants and nurse practitioners may also specialize in hospital medicine and are an important part of the team. All have become an integral part of providing comprehensive

[24] SHM, http://www.hospitalmedicine.org/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx (accessed November 3, 2014).

[25] SHM, http://www.hospitalmedicine.org/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx (accessed November 3, 2014).

[26] SHM, http://www.hospitalmedicine.org/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx (accessed November 3, 2014).

medical care to patients. There is no indication that the number of practicing hospitalists will decrease in the near future.[27]

Benefits and Proponents of Hospitalists

The literature reports many benefits of this specialty. One valuable asset is the availability and presence of the hospitalist team. For example, "….one of the greatest strengths of the hospitalist model -- the presence of a physician in the hospital throughout the day who is able to coordinate inpatient care and react to clinical data in real time."[28] This can lower the wait time for admission in the emergency room or expedite a patient's medical clearance for surgery. The availability of hospitalists is important to both hospital administrators and direct care providers. No longer are nurses waiting for PCPs to complete office hours before managing care of hospital patients. In the hospitalist medicine model, nurses only need to contact the on-call hospitalist for the unit. This expedited response is anticipated to proactively defuse medical emergencies. Thus, patients may be discharged sooner with a subsequent savings in the additional costs associated with another day in the hospital.[29]

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[27] Peter D. Kralovec, Joseph A. Miller, Laurence Wellikson, and Jeanne M. Huddleston, "The Status of Hospital Medicine Groups in the United States," *Journal of Hospital Medicine* 1, no. 2 (March/April 2006): 79.

[28] Wachter, Goldman, and Hollander, 3.

[29] Michael C. Peterson, "A Systematic Review of Outcomes and Quality Measures in Adult Patients Cared for by Hospitalists vs Non-hospitalists," *Mayo Clinic Proceedings* 84, no. 3 (March 2009): 249.

Research conducted by Ann Scheck McAlearney[30] has identified potential benefits of the hospitalist model to the family physician. McAlearney performed an integrative review of published articles about the hospitalist model and its influence and effect on family practice. McAlearney found there are potential benefits to family physicians with the hospitalist model of care such as "increased office productivity with less disruption of office schedules, extra time for outpatients, reduced travel time, improved outpatient satisfaction, and increased provider satisfaction with ability to specialize in outpatient care."[31] The family physician may also experience less stress by not going to the hospital. The loss of the physician's hospital revenue can be offset by the increase of patients in the office setting.[32]

An added benefit has been the involvement of hospitalists on hospital-wide committees and task force groups. Potential additional hospitalist undertakings include involvement in quality improvement and patient safety teams and information/technology focus groups, as well as in the triage and transfer of patients between various departments in the hospital.[33] The hospitalists may see trends or report significant findings to the appropriate administrator in a more timely fashion since they are hospital-based. Hospital executives have seen this involvement in the hospital infrastructure as a positive

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[30] Ann Scheck McAlearney, "Hospitalist and Family Physicians: Understanding Opportunities and Risks," *Journal of Family Practice* 6 (June 2004): 473-481.

[31] McAlearney, 478.

[32] McAlearney, 478.

[33] Wachter, 701.

change.[34] In addition, hospitalists have a vested interest in the success or failure of the institution because their practice is based solely within the hospital.

Professional organizations representing physicians offer their support of hospitalist programs. For example, the American Academy of Family Physicians (AAFP)[35]comments that hospitalist programs are acceptable as long as participation in them is voluntary, for both patients and PCPs.[36] AAFP has developed guidelines for the success of a hospitalist program and maintenance of the doctor-patient relationship. The primary focus of their guidelines is communication (see Appendix A).[37]

Many health care providers support and believe in the hospitalist model. PCPs who utilize hospitalists to deliver care to patients can concentrate on responsibilities and issues of the outpatient medical practice. The acutely ill in the hospital can benefit from

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[34] Terese Hudson Thrall, "Hospitalists: A Specialty Coming into Its Own," *Hospital and Health Networks Magazine* (November 2003): 70.

[35] "The American Academy of Family Physicians (AAFP) is one of the largest national medical organizations, representing more than 100,300 family physicians, family medicine residents and medical students nationwide. Founded in 1947, its mission has been to preserve and promote the science and art of Family Medicine and to ensure high-quality, cost-effective health care for patients of all ages." http://www.aafp.org/online/en/home/aboutus.html?navid=about+us (accessed October 23, 2011).

[36] AAFP. http://www.aafp.org/practice-management/administration/hospitalists.html (accessed November 9, 2014).

[37] AAFP. http://www.aafp.org/practice-management/administration/hospitalists.html (accessed November 9, 2014).

having physicians on-site to manage their care; these hospitalists are trained to treat the seriously ill.[38]

The proponents also cite the potential cost savings of the hospitalist model, from which hospitals as well as insurance companies may benefit. Because of around-the-clock coverage and management, patients may be discharged earlier from the hospital, and this may be due in part to prompt review of laboratory and diagnostic results by the hospitalists. In addition, the familiarity with the hospital system and internal workings may expedite the management of care, thereby leading to prompt discharge. Many hospitalists are involved in quality and safety committees whose focus is to improve patient care and provide a safe environment for patients. Through their participation of these committees, hospitalists become familiar with current issues and policies at the hospital.

The hospital itself is a proponent of hospitalist medicine. The hospitalist team frequently maintains an office at the hospital and has access to up-to-date patient information. Furthermore, the use of electronic health records has streamlined the accessibility of patient results. Additionally, they are available for last minute pre-operative clearances and peri-operative management. Again, by having hospitalists, acute care facilities avoid a delay in care related to waiting for PCPs to complete office responsibilities prior to coming to hospitals for rounds and patient-related issues.

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[38] Dagmara Scalise, "Hospitalist: In-house Docs Can Ease Some Vexing Problems, But First You've got to Win over the Skeptics," *Hospital and Health Networks Magazine* (June 2006): 58.

The national/professional organization for hospitalists, the SHM, is one of the biggest proponents of the model of care. The SHM reports that they are "leading the transformation and improvement of care for the hospitalized patients through innovation, collaboration, and action."[39] The society supports hospitalists by providing advocacy, education, training, and research.

Limitations and Opponents of Hospitalists

Physicians may worry that hospitalists will interfere with the traditional doctor-patient relationship. Patients may be less willing to speak openly to hospitalists about health issues. There is also a concern that miscommunication and patient dissatisfaction can occur when control shifts back and forth between a patient's regular PCP and a hospitalist.[40]

PCPs who currently balance their responsibilities caring for office patients along with their hospitalized patients may be concerned with the management changes associated with hospitalist medicine. They are also apprehensive that hospitalists could disrupt their relationship with the acute care facility.[41] Hospitals may become more comfortable with hospitalists who routinely perform rounds and manage the care of the hospitalized patients. As a result hospitalists may be preferentially sought out to serve on

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[39] SHM, http://www.hospitalmedicine.org/Web/About_SHM/Industry/Mission_Statement_and_Objectives.aspx (accessed November 3, 2014).

[40] Wachter, 338.

[41] Scalise, 57.

committees or hospital task forces and assume leadership roles within the hospital, instead of PCPs who no longer see patients at the facility. The potential for PCPs to feel out of touch with the hospital can become a significant issue.

Potential disadvantages of the hospitalist model also include loss of information as a result of discontinuity of care. "Most errors result from problems created by today's complex health care system. But errors also happen when doctors and patients have problems communicating."[42] The importance of a well-designed method of communication between hospitalists and PCPs cannot be overstated. Patients may be upset over the transfer of care to hospitalists, who are frequently unknown to them, and patient dissatisfaction with this break in continuity of care can occur. If feasible, patients may opt to use the services of another PCP who self-admits to the hospital. If this became a precedent, PCPs who hand off care to hospitalists can be impacted economically due to reduced patient visits.

In summary, hospitals must strive to meet the highest standards in providing care regardless of which model of care is utilized. Hospitalist medicine requires commitment from physicians, nurses, ancillary health care providers, and hospital administrators.[43] Patient satisfaction needs to be measured and evaluated as the relationship between PCPs and patients evolves within this new system of patient care management.

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[42] US Department of Health and Human Services Agency for Healthcare Research and Quality, http://www.ahrq.gov/patients-consumers/care-planning/errors/20tips/index.html (accessed November 9, 2014).

[43] O'Leary and Williams, 421.

Members of the Health Care Team

Many acute care facilities throughout the nation are providing inpatient care utilizing the hospitalist model. The success of the hospitalist model requires coordination and leadership from hospitalists and hospital administrators along with buy-in from PCPs. While the hospitalist is the primary provider in the model, many other health care professionals including nurses, physician assistants, and consultants are involved in patient care. All strive to provide care and meet the goals of sick patients.

Primary Care Providers

As per the U.S. National Library of Medicine National Institute of Health, "a primary care provider (PCP) is a health care practitioner who sees people that have common medical problems. This person is usually a doctor, but may be a physician assistant or a nurse practitioner."[44] In the traditional model of hospital medicine, during hospitalizations, PCPs conduct and document an admission history and physical examination including routine medications and medical history. New medications, diagnostic testing (i.e., chest x-ray, electrocardiogram, and blood work), and consultation with other physician specialists, if necessary, are ordered. The patient remains hospitalized until stable for discharge as determined by the PCP who is managing hospital care. Once discharged, the PCP will continue to follow the patient as an outpatient, as appropriate.

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[44] National Institutes of Health, http://www.nlm.nih.gov/medlineplus/ency/article/001939.htm (accessed November 3, 2014).

Nurse Practitioners

Many physicians will utilize nurse practitioners (NPs) to assist in delivering medical care to their patients. NPs are masters-prepared registered nurses who have additional training and education in diagnosing, treating, and providing care to patients. They are certified at the national level and licensed by the State in which they practice. As per the American Association of Nurse Practitioners, "NPs have been providing primary, acute, and specialty health care to patients of all ages and walks-of-life for nearly half a century. NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans – including prescribing medications."[45] NPs have important roles in both outpatient primary care settings and in acute care. NPs are able to deliver care to hospitalized patients and can also function in the hospitalist role.

Physician Assistants

Physician Assistants (PAs) are licensed medical professionals. Similar to NPs, they are certified at the national level and provide medical care to patients. As stated on the American Academy of Physician Assistants' webpage, some of the roles that PAs are licensed to perform include, "obtaining a medical history, performing physical exams, diagnosing and treating illnesses, ordering and interpreting tests, and making rounds in hospitals and nursing homes."[46] PA roles may vary depending on where he/she works and his/her level of experience. PAs frequently work in the hospital setting providing

[45] American Association of Nurse Practitioners, http://www.aanp.org/all-about-nps (accessed November 3, 2014).

[46] American Academy of Physician Assistants, http://www.aapa.org/twocolumnmain.aspx?id=290 (accessed November 3, 2014).

care to acutely-ill patients. These professionals are an excellent source of support for physicians. The use of NPs and PAs allows physicians to dedicate time and expertise to more complex cases.

Consultants

Consultations are indicated when patients have underlying medical conditions or complex acute problems that require treatment from advanced, specialized doctors. These consultants are physicians who have advanced education and training in a particular area of medicine. Examples of consultations that are frequently necessary in the hospital setting include, but are not limited to, the following:

Cardiology consults: Cardiology consults may be needed for a patient with an underlying condition such as atrial fibrillation or heart rhythm abnormalities, heart failure, or myocardial infarction (heart attack). A patient may also have a cardiology consult prior to undergoing an invasive or surgical procedure to determine if the patient is medically stable for the proposed intervention.

Infectious Diseases consults: Infectious diseases consults may be necessary to manage advanced, difficult-to-treat infections, caused by a variety of pathogens. Patients may be admitted to the hospital with a pre-existing infection or can develop an infection while hospitalized (i.e., nosocomial infection or hospital-acquired infection). Such infections frequently require the expertise of an infectious disease practitioner for proper management.

Endocrine consults: Endocrine consults may be utilized for newly diagnosed uncontrolled diabetes or any conditions involving the endocrine system. Once the patient is stable, endocrine conditions frequently require follow-up as an outpatient.

Renal, Pulmonary, or Neurology consults: Consults for underlying kidney, lung, or brain/nerve conditions respectively are frequently warranted in the hospital. Patients may have a pre-existing condition that may worsen during the hospitalization, thus requiring the expertise of a specialist. Hemodialysis, which is indicated with kidney failure, is occasionally required in the acute care setting, thus mandating a renal consultation.

Nursing consults: In the hospital setting, nurses have various roles. One important function is that of a skin and wound care specialist. Wound and skin care are areas where consultation is frequently requested during a patient's hospitalization. Wound care nurses can provide guidance on the best measures to prevent and treat conditions that are related to impaired skin integrity. This wound care specialist is the best resource for current products and techniques and can contact hospital vendors when needed. Frequently, wound care nurses will see patients after they are discharged to continue management of their skin- and wound-related conditions.

It would be remiss not to mention the nursing department as members of the team delivering hospital care. Nurses work in collaboration with physicians in the care of their patients. The nursing staff routinely functions as the patient advocate. They are with the patient around-the-clock, frequently communicate with designated family members, and interact with hospitalists who are managing patient care. The bedside nurse coordinates

care within the hospital between the various departments (for example: pharmacy, radiology, and dietary).

Care Managers and Social Workers

At the majority of tertiary care institutions, nurses are care managers. They follow patients throughout their hospitalization and begin the process of discharge planning at the time of admission. Collaboration with social workers on individual cases is another important role. Care managers and social workers partner closely with hospitalists in anticipating and addressing the discharge needs of patients.

Residents

If the hospital is associated with a medical school or university, another key "player" patients may encounter is a resident--a physician completing his or her training in the hospital setting. Residents planning a career in general medicine are called medical residents. Those who will become surgeons are referred to as surgical residents. Residents are assigned patients to manage and treat during hospitalizations. They work under the guidance of PCPs or hospitalists in the delivery of care.

Ancillary Health Care Providers

A hospital also needs numerous ancillary health care providers who work with the medical and nursing staff to deliver care to patients. Examples of ancillary health care providers include but are not limited to respiratory therapists who deliver pulmonary treatments, electrocardiogram (EKG) technicians who record and report EKG's, phlebotomists who draw and process blood samples, and dieticians or nutritionists whose primary functions are to assess and manage the nutritional and dietary needs of patients.

These professionals conduct their duties with the primary focus on patient care and improving patient outcomes.

Communication

In health care, effective communication is critical. If information is lost, incomplete, or even misinterpreted, serious consequences can occur. In the acute care setting, which can often be hectic and chaotic, the communication skills of practitioners are often challenged by the external factors of the hospital setting. "Breakdowns in communication between physicians and patients lead to patient anger and dissatisfaction and possible litigation."[47] Physicians must demonstrate communication proficiency to maintain a satisfactory relationship with patients. This is especially true for physicians who function as hospitalists because they manage patient care for other physicians and routinely do not have an established relationship with patients. They meet patients at the hospital when admission for treatment is needed. Communication and rapport must be quickly established between hospitalists and patients to accurately exchange information regarding the current medical condition and hospital treatment plan.

Traditionally, the doctor-patient relationship develops over time. In many cases an entire family is under the care of one PCP's practice. In fact, multiple generations of a single family may see the same PCP for medical care. The advantages are that physicians become aware of familial and peripheral circumstances that may affect care. PCPs

[47] Wendy Levinson et al., "Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons," *Journal of the American Medical Association* 277, no. 7 (February 1997): 553.

acquire an understanding of socioeconomic factors that may affect care or decision-making processes. During hospitalization, it is imperative to remember that PCPs are an important part of an individual's health care team and should remain informed in the event of hospitalization for an acute medical problem.

Merriam-Webster defines communication as "the act or process of using words, sounds, signs, or behaviors to express or exchange information or to express your ideas, thoughts, feelings, etc., to someone else."[48] Open communication among PCPs, patients, and hospitalist teams is essential in hospitalist medicine. Sharing information regarding the patient's medical history, medication usage, and end-of-life care decisions is vital to the ethical care of patients. Communication is time-sensitive and must be accurate to avoid not meeting patient expectations.

Although hospitalists primarily manage patient care in the hospital, they can function independently in private practices, can be employees of a corporation specializing in hospital medicine, or be employed by the acute care facility. Their primary function is to manage care on behalf of PCPs, until the time of discharge.

According to Peter Barnett, hospitalists need to develop and maintain a therapeutic relationship with their patients.[49] However, many factors can affect the development of this connection. The acuity of illness can affect the development of a therapeutic relationship. When acutely ill, patients may perceive inattention or lack of interest on the part of others, including physicians. The anxiety of being in the unfamiliar

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[48] Merriam-Webster, http://www.merriam-webster.com/ (accessed November 14, 2014).

[49] Peter B. Barnett, "Rapport and the Hospitalist," *The American Journal of Medicine* 111, no. 9 (December 21, 2001): 31.

hospital environment may hinder the patient's ability to bond with hospitalists. In addition, limits on the amount of time that hospitalists can spend at the bedside can affect the nurturing of this relationship. Barnett further delineates imperative components for establishing a rapport with patients. These characteristics include "partnership, empathy, apology, respect, legitimation, and support."[50] As with any relationship, nonverbal communication cues are also important and need to be acknowledged in the building of a relationship with the patient.[51]

The transient nature of the doctor-patient relationship in hospitalist medicine makes establishing a rapport difficult and challenging. Communication is often affected by the seriousness of illness and the surrounding stressful hospital environment. Patients and physicians, including hospitalists, need to establish a dialogue conducive to clinical decision-making. Both parties need to focus on the primary goals of the patient. Individual patient goals can vary depending on underlying condition(s). Hospitalists need to be aware of established medical conditions and patient expectations in order to provide adequate and appropriate care. Effective communication, with the dynamic exchange of health care related issues and concerns, must occur to ensure the delivery of appropriate patient care.[52]

Open and accurate communication among PCPs, patients, and hospitalists is essential in hospitalist medicine. Communication lines must remain open not only at the

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[50] Barnett, 34.

[51] Barnett, 37.

[52] Laura Min Mercer et al., "Patient Perspectives on Communication with the Medical Team: Pilot Study Using the Communication Assessment Tool-Team (CAT-T)," *Patient Education and Counseling* 73, no. 2 (November 2008): 220.

time of admission when pertinent information regarding the patient's medical history is transcribed, but also throughout the hospitalization. Patient conditions can change in an instant, thereby altering the direction of care. Communication with patients and PCPs is paramount to rendering seamless care. However, most important is to convey a clear picture of the patient's history and current condition to avoid errors, such as those involving medication administrations.

The relationship between PCPs and patients can extend and expand over many years; the importance of this bond cannot be overvalued. Patients see their PCP in his/her private office during pre-scheduled appointments. The medical narrative of the patient continues to develop with each visit and is appropriately documented in the medical record. Hospitalists, on the other hand, encounter patients in a time of dire need. Most frequently, the emergency room (ER) is the point of initial contact. The ER environment is not conducive to relationship development. In fact, the atmosphere can be chaotic and disruptive, making it difficult to establish any type of connection with a patient. Complicating matters at this time, the patient may also be coming to terms with the fact that his/her PCP will not be managing care during the hospital stay.

Hospitalist medicine continues to evolve. Effective patient communication accompanied by positive patient satisfaction, will support the hospitalist model. However, communication with PCPs must also be a priority. This will help facilitate the decision-making process during the hospitalization. PCPs possess vital information regarding patients, which must be included in the planning of care.

Doctor-Patient Considerations

Hospitalist medicine offers many benefits to PCPs but this approach is not without risks. Potential risks to PCPs include, "discontinuity in patient care and communication issues regarding patient care, loss of information about patient wishes, reduced contact with hospital-based professionals and specialists, loss of influence at admitting hospitals, and loss of hospital privileges."[53] The benefits and risks need to be carefully considered when physicians evaluate the use of hospitalists.

Many patients have a well-developed professional bond with their PCPs. PCPs have gotten to know their patients along with their families over many years or perhaps in some instances, several generations. Because of this familiarity, the relationship can surpass the initial patient-PCP interaction and become more important to the patient. When functioning within the hospitalist model of care, at the time of hospitalization when patients feel most vulnerable, PCPs are not available, so care is temporarily deferred to hospitalists. Feelings of abandonment and isolation may occur. Patients may experience a sense of loss without the involvement of their PCPs.[54]

Patients may believe their physician no longer sees them in the hospital for a variety of reasons: general lack of concern, outpatient office priorities, financial constraints, or perhaps insurance companies' attempts to increase profits at their expense. It is understandable that patients may feel neglected by PCPs under the hospitalist medicine model. They need to be reassured that PCPs remain an important part of their

[53] McAlearney, 478.

[54] Lee Goldman, "Hospitalists as Cure for Hospitalism," *Transactions of the American Clinical and Climatological Association* 114 (2003): 43.

health care. Input from PCPs is obtained to ensure the delivery of safe, efficient, and effective care.

Hippocratic Oath and Ethical Concerns

The doctor-patient relationship has been documented since ancient times. Hippocrates, the "father of medicine,"[55] developed standards by which physicians still practice today, and his writings continue to be referenced in medical publications. The Hippocratic Oath is frequently recited by new physicians graduating from medical schools as a ceremonial rite of passage from student to practicing physician. The Oath has been modified from its classical Greek origin (see Appendix B) and updated to a modern version to reflect more current indications and the functions of today's physicians (see Appendix C), but the basic tenets remain the same, and its guiding message is considered the gold standard for the practice of medicine.

A passage from the modern version of the Hippocratic Oath states, "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."[56] Are PCPs who utilize the services of hospitalists not meeting their responsibilities under the Hippocratic Oath? Are they shirking their obligations by referring patient care to hospitalists? By selectively only caring for patients in the office setting, are they not treating related

[55] Audrey Cruse, *Roman Medicine*, (Great Britain: Tempus Publishing, Ltd., 2006), 39.

[56] Louis Lasagna, "Hippocratic Oath," (Massachusetts: Tufts University, 1964) (see Appendix C).

problems as implied in the Oath? Hospitalist medicine challenges the standards implied in the Oath.

One could argue that hospitalists do not treat human beings as referenced in the Oath. They only treat during acute illness and then hand off care back to PCPs. More specifically, hospitalists treat patients' current disease processes, stabilize them, and discharge patients back to the care of PCPs.

If PCPs no longer provide care in the hospital, are they able to adequately care for the sick? Hospitalized patients are acutely ill. They are too sick to be managed at home and hospitals possess extensive advanced technology required to care for them. It has been posited that PCPs who utilize the services of hospitalists will no longer be able to keep up with the challenging, ever-changing high-tech care of hospital medicine because they no longer manage patient care in the facility. It is very difficult for office-based PCPs to stay abreast of these new therapies without routinely rendering care in the hospital.

The Hippocratic Oath reflects the fundamental ethical duty of confidentiality. Considerations regarding the patient's right for privacy and confidential health care can be found in both the modern and classical versions. Hippocrates notes, "I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know."[57] Throughout the doctor-patient relationship, sensitive personal issues are addressed, such as end-of-life wishes. Discussions, translations, and interactions may be

[57] Louis Lasagna, "Hippocratic Oath," (Massachusetts: Tufts University, 1964) (see Appendix C).

lost when care is discontinued by PCPs and transferred to hospitalists.[58] Pantilat, Alpers, and Wachter argue,

> The traditional patient-primary care physician (PCP) relationship provides many ethical protections for patients, including confidentiality, shared medical decision-making, and respect for patient autonomy. Hospitalist models, which introduce a purposeful discontinuity of care, threaten these protections and raise certain ethical concerns.[59]

Hospitalist medicine must protect patient autonomy at all costs. The virtues of the Hippocratic Oath taken by physicians must be respected in this new model of care. Communication is an important aspect of protecting and guarding the PCP-patient relationship.

Predominantly, hospitalists meet patients for the first time in the emergency room (ER). When this occurs, PCPs should provide a detailed review of the patient's health history to the hospitalist along with pertinent family or social concerns deemed necessary for the appropriate medical treatment of the patient. However, the patient may feel that confidentiality is violated in the disclosure of his/her medical history to a new, unknown doctor. This scenario proves to be challenging for the hospitalist, patient, and PCP and is contrary to the core values of the Hippocratic Oath, which specifically addresses patient confidentiality.[60] Patients are able to discuss personal and confidential issues with their physician without fear of disclosure due to the confidentiality obligations that their physician honors. However, disclosure to another party for appropriate medical

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[58] Steven Z. Pantilat, Ann Alpers, and Robert M. Wachter, "A New Doctor in the House: Ethical Issues in Hospitalist Systems," *Journal of the American Medical Association* 281 (July 14, 1999): 171.

[59] Pantilat, Alpers, and Wachter, 171.

[60] Cruse, 212.

treatment may be necessary in the hospitalist system. The sharing of medical information between PCPs and hospitalists may make patients uncomfortable and skeptical of their right to confidentiality.

Hospitalists should also consult PCPs about major decisions. "Good hospitalists will involve the PCP when decisions are ethically charged, the stakes are high, or the appropriate course is unclear."[61] PCPs have routinely been the source of information regarding patient medical history and health care wishes, including advanced directives. PCPs need to be consulted to ascertain much needed patient history to aid in the decision-making process.

Warmth and sympathy are both mentioned in the Hippocratic Oath. Patients may believe PCPs are not very sympathetic to their needs when they do not provide care to them in the hospital. The private outpatient office may frequently be the environment where warmth and sympathy are displayed through the therapeutic relationship between PCPs and patients. However, the same may not be experienced during the medical crisis, which brings patients to the hospital and into the path of hospitalists. Frequently evaluated in the ER, patients may not find the environment conducive to developing a therapeutic relationship.

The Hippocratic Oath provides physicians with guidance in delivering care to patients. Physicians should provide the best care possible and support patients in decision-making when necessary. If PCPs are no longer involved in patient care at the hospital, are they able to provide the best care possible within the guidelines of the

[61] Pantilat, Alpers, and Wachter, 172.

Hippocratic Oath? PCPs can fulfill their obligations and commitments as long as the communication among patients, PCPs, and hospitalists remains open and dynamic.

The doctor-patient relationship provides ethical protections for patients. It offers these protections by respecting confidentiality, shared decision-making, and autonomy. Hospitalist medicine involves a temporary discontinuation of care with PCPs, thus these protections can be threatened and ethical concerns raised.[62] Bernard Lo states,

> Respect for persons includes respect for patient autonomy. Autonomy refers to the power or right to control one's own life and body. Autonomy usually entails making informed decisions about medical care, such as choosing a physician and choosing among options for care. Because patients usually cannot choose whether to use a hospitalist system and have no choice of inpatient physician, hospitalist arrangements may diminish patient autonomy. Hospitalist systems may also hinder patients' ability to make informed choices on clinical issues by reducing the role of the primary care physicians.[63]

As previously discussed, hospitalist medicine has existed for just under twenty years. Many people are still unfamiliar with the concept and its subsequent implications. The decision-making processes to which patients are accustomed have changed. PCPs are "replaced" in the hospital with hospitalists who are guiding and managing patients' care. In the outpatient setting, patients select PCPs. In the inpatient environment, with the hospitalist model of care, no choice is given. Upon arrival to the hospital, people are assigned to be under the care of hospitalists if the facility practices within this model of care. Patient autonomy, with regard to physician selection and care during hospitalization, is not respected.

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[62] Wachter, Goldman, and Hollander,76.

[63] Bernard Lo, "Ethical and Policy Implications of Hospitalist Systems," *The American Journal of Medicine* 111 (December 2001): 49.

Many hospital systems offer hospitalist medicine services to attending physicians (i.e., physician has the option of using this service). Some insurance companies even mandate the use of hospitalists in the acute care setting.[64] However, the SHM supports voluntary rather than mandatory hospitalist use for PCPs.[65] This policy allows for physician autonomy in the practice setting.

End-of-life decisions are frequently an ethical concern for acutely ill patients and their families. Hospitalists are at a disadvantage, since they lack the long-term relationship that many PCPs have with their patients. Hospitalists have not been part of the outpatient decision-making process. However, hospitalists need to demonstrate comfort and skill in discussing advance directives with hospitalized patients.[66] In some circumstances, there will be little to no time for discussion. Hospitalists will need to guide patients and their families in the decision-making process. Wachter states, "By applying basic ethical principles and communicating effectively with patients, surrogates, and other members of the health care team, physicians can resolve nearly all ethical dilemmas that arise in the hospital."[67]

As described, patients develop professional, therapeutic relationships with their PCPs over time. When functioning within the hospitalist model of care, at the time of

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[64] Adam Haley Rosenbloom and Alan Jatkowitz, "The Ethics of the Hospitalist Model," *Journal of Hospital Medicine* 5 (March 2010): 185.

[65] SHM, http://www.hospitalmedicine.org/Web/Advocacy/Where_we_stand_sub/Coordinationg_with_Primary_Care.aspx (accessed March 18, 2015).

[66] Wachter, Goldman, and Hollander, 76.

[67] Wachter, Goldman, and Hollander, 76.

hospitalization, PCPs defer patient care to hospitalists. It is when patients feel most vulnerable, such as with the occurrence of an acute illness requiring hospitalization, that the relationship between PCPs and patients is temporarily severed. Patients may reasonably feel neglected by PCPs under the hospitalist medicine model of care. Patients require reassurance that their care is being managed with guidance from PCPs, when applicable.

The ethics of the delivery of care, along with the protection of patients' rights, can be optimized in order to provide a safe, therapeutic experience. Hospitalists need to establish a rapport with patients to effectively meet patient expectations and goals. They can then work together to achieve these goals.

Consultation with PCPs by hospitalists is critical. Patients and families need to be reassured that hospitalists and PCPs are working together as a team to provide care. PCPs are notified by hospitalists at the time of hospital admission. However, it is also imperative that PCPs be informed by hospitalists of changes in patients' conditions. The professional relationship of PCPs and hospitalists must occur in "real time" to avoid any irrational or ill-informed decisions.[68] Collaboration and communication are key ingredients for success. Involvement of PCPs in important decision-making, as indicated, will provide patients and families with additional support.

Once patients are hospitalized, hospitalists must form a partnership with them. As in any doctor-patient relationship, the family should be involved whenever applicable. Patients should be aware of diagnoses, treatments, test results, and follow-up care. Lee

[68] Lee Goldman, Steven Z. Pantilat, and Winthrop F. Whitcomb, "Passing the Clinical Baton: 6 Principles to Guide the Hospitalist," *The American Journal of Medicine* 111 (December 2001): 37S.

Goldman, Steven Z. Pantilat, and Winthrop F. Whitcomb, nationally recognized specialists in hospital medicine, state, "The hospitalist must develop a bond with the patient, especially because the interaction is occurring at one of the most critical times of life."[69] Frequent exchange of information may be necessary to treat the acutely ill patient. This exchange may occur via telephone calls or electronic updates to PCPs.

Hand-offs and Ethical Concerns

The shift from hospital to home can be a time of stress and concern due to the transfer of care from hospitalists back to PCPs. The transition of care to PCPs is called the "hand-off."[70] This is one of the most important aspects of hospitalist medicine. The hand-off is a crucial time when current medical information about the patient is communicated.

Open communication and disclosure will help to dissipate any concerns that patients have regarding hospital medicine. The communication should include topics including who will be responsible for admission and discharge from the hospital; who will examine and interpret testing and lab results; and how this will be communicated to PCPs and patients. Identification of the contact person for patients and the communication of pertinent information, such as living wills and health care proxy documentation, are also very important topics for discussion. The transfer of care to hospitalists at the time of admission needs to include and address these important aspects

[69] Goldman, Pantilat, and Whitcomb, 38S.

[70] Wachter, Goldman, and Hollander, 3.

of patient care; and patients should be made aware of such agreements at the time of their initial contact with PCPs.

Sunil Kripalani and associates report, "The period following discharge from the hospital is a vulnerable time for patients. About half of adults experience a medical error after hospital discharge, and 19%-23% suffer an adverse event, most commonly an adverse drug event."[71] The high rate of these situations emphasizes the importance of the discharge summary, which will provide PCPs with vital information from the hospitalization.

The information contained in the discharge summary must be complete, accurate, and up-to-date. The Joint Commission (JC) established standards (RC.02.04.01, see Appendix D),[72] which supplied guidelines for components of hospital discharge summaries. First, the reason for the hospitalization should be stated. Significant findings, care, procedures and treatments provided need to be reported. Patients' discharge condition and disposition along with patient and family instructions should be clearly delineated. Provision for follow-up care needs to be communicated.[73] The discharge summary may be disseminated electronically via fax or integrated into a shared electronic health record database. The discharge summary provides PCPs with valuable information about the hospitalization. "Hospitalists should bridge the gap between

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[71] Sunil Kripalani, Amy T. Jackson, Jeffrey L. Schnipper, and Eric A. Coleman, "Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists," *Journal of Hospital Medicine* 2 (Sept/Oct 2007): 314.

[72] Joint Commission, https://e-dition.jcrinc.com/MainContent.aspx (accessed November 20, 2014).

[73] Joint Commission, https://e-dition.jcrinc.com/MainContent.aspx (accessed November 20, 2014).

inpatient and outpatient care with effective communication between all parties – patients, family members, and outpatient physicians in particularly the PCP."[74] Effective communication will aid in minimizing errors and misinformation.

The professional relationship of PCPs and hospitalists must remain open for dialogue to avoid any irrational or ill-informed decisions regarding patient care.[75] The timely dissemination of a discharge summary will supply PCPs with information on the current condition of the patient. Ideally, discharge summaries should be dictated at the time of discharge.

Not only do care transitions occur at the time of discharge; they also occur at the time of hospital admission. The discontinuation of care from PCPs can raise ethical concerns because of the change in the relationship between PCPs and patients. During the development of the doctor-patient relationship, the patient's goals and values regarding medical decision-making are discussed. Without effective communication, the discontinuation of care from PCPs can also lead to patient dissatisfaction.[76] This can occur when patients have not anticipated the sudden hand-off of their care and/or patients are not satisfied with the lack of choice in their hospitalists. In addition, according to Dr. Steven Pantilat, a nationally recognized specialist in hospital medicine, communication-related ethical issues arise with the hospitalist system of care:

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[74] Kripalani et al., 320.

[75] Goldman, Pantilat, and Whitcomb, 37S.

[76] Sunil Kripalani et al., "Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physician: Implications for Patient Safety and Continuity of Care," *Journal of the American Medical Association* 297, no. 8 (February 28, 2007): 831.

> Fundamental ethical duties such as confidentiality and principles such as respect for patient autonomy and beneficence support these agreements and protect the patient's individuality and well-being. However, because hospitalist systems leave no formal inpatient role for the PCP, they may compromise these ethical values. Patients can no longer rely on agreements reached in the office following them to the hospital.[77]

Further, in an article regarding ethical and policy implications of hospitalist systems, bioethics expert Dr. Bernard Lo wrote, "Practice standards should be set for communication between PCPs and hospitalists and for involvement of primary physicians in inpatient care under certain circumstances." [78] Hospitalist medicine continues to develop to meet the needs of health care facilities. But it can only be effective if communication between patients and hospitalists is developed and maintained. Communication with PCPs and their patients cannot be emphasized enough.

PCPs have developed a contract or working relationship with the hospitalist team wherein it is agreed that the team will manage the care of PCPs patients at the time of hospitalization. When discharged, patients are then referred back to their PCP. It is a preplanned arrangement and agreement.

The communication lines must remain open not only at the time of admission where pertinent information regarding the patient's medical history is transcribed, but also throughout the hospitalization and eventual discharge. Patient conditions can change in an instant, requiring a change in the direction of care. Communication with PCPs is

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[77] Pantilat, Alpers, and Wachter, 171.

[78] Lo, 48.

essential in maintaining the continuity of patient care and effective communication channels need to be identified and utilized in order to achieve this goal.

Example One for Importance of Communication

A patient is admitted with pneumonia (lung infection) and requires intravenous (IV) antibiotics. However, due to illness and immobility, a deep vein thrombosis (DVT/ blood clot) develops in his/her legs. The patient's condition is now more critical. In addition to antibiotics, the patient requires anticoagulation for treatment of the DVT. During the hospitalization, the administration and management of new medications are overseen by hospitalists. In addition, hospitalists interpret lab and diagnostic testing and obtain consultations as indicated.

At the time of discharge, medications, activities, and dietary restrictions along with follow-up appointments (in particular, follow up with the patient's PCP) are discussed. Prescriptions for any new medications are given. In the case of the above example, the patient will be discharged on anticoagulation therapy in the form of warfarin (Coumadin). The patient will require frequent blood work to monitor clotting times (INR) since warfarin is a medication that will delay the clotting ability of the blood. At the time of discharge, it will now be the PCP's responsibility to oversee care, including the delicate balance of warfarin dosing and clotting times, in addition to any other medical issues that may arise. Lack of communication with the PCP in this scenario could lead to further complications or death of the patient, because of the increased risk of bleeding with anticoagulation.

Example Two for Importance of Communication

A patient is admitted after experiencing a fall (a common reason for admission to an acute care setting). Pre-existing medical conditions are reported as hypertension and coronary artery disease. Prior to admission, the patient was managed with four medications: a diuretic (water pill), ACE-inhibitor, beta-blocker, and calcium channel blocker (anti-hypertensives and heart medications). During the hospital admission, it is discovered that the patient has periods of orthostatic hypotension (low blood pressure upon standing), so the blood pressure medications are adjusted. At the time of discharge, the patient remains on the diuretic and beta-blocker. The ACE-inhibitor and calcium channel blocker have been discontinued because it was determined that they contributed to the hypotensive episodes resulting in the fall. Along with the patient, the PCP needs to be notified of these medication changes. Without proper notification and disclosure, the patient might resume pre-admission medications, as per the PCP medical records, and possibly sustain another fall.

As the previous examples demonstrate, PCPs need to be updated regarding diagnoses from admission to discharge. Significant findings that occurred during the admission must be communicated for unified care to be delivered. Patient safety must be a priority and failure to disclose new diagnoses and/or medications can have grave consequences. The potential for hand-off errors is present and needs to be minimized.

Hospitalist medicine experts Goldman, Pantilat, and Whitcomb[79] identify six principles to guide the hospitalist in the hand-off procedure:

1. Communicate, but do not irritate
2. Consult the primary care physician
3. Timeliness is next to godliness
4. Partner with the patient
5. Make it clear that you are the patient's advocate
6. Pass the baton as graciously as you received it (or even better, more graciously)[80]

In summary, communication is the key in hospitalist medicine. The ethics in the delivery of care along with the protection of patient's rights can be optimized to provide a safe, therapeutic experience. Communication can occur via telephone, personal meeting, or electronically via fax, personal digital assistant (PDA), or email. It should be determined which mechanism works best for each relationship. Once decided, consistency needs to be maintained. For example, it may be determined that upon admission a telephone call is made between hospitalists and PCPs. Upon discharge, a complete note is faxed to PCPs offices.[81] This complete note (also known as the discharge summary) will become part of the patient's electronic medical health record or paper office chart.

[79] Goldman, Pantilat, and Whitcomb, 36S-39S.

[80] Goldman, Pantilat, and Whitcomb, 38S.

[81] Goldman, Pantilat, and Whitcomb, 37S.

Literature Review

Electronic databases CINAHL and Medline were utilized to conduct a literature review identifying publications related to communication and hospitalists. Searches were performed using the following subject headings: patient, patient satisfaction, communication (including communication barriers, communication skills, and conversation), doctor-patient communication, and hospitalists.

A wealth of information has been published on physician communication and patient satisfaction. The long-standing relationship between physicians and patients has evolved into one in which patients have interactions with many specialists and consultants, not only with his/her PCP. Communication must be viewed by patients as effective for them to be satisfied with their care.

One of the earliest published studies was conducted by Korsch, Gozzi, and Francis. [82] The aim of the study was to determine the relationship between doctor and patient communication and outcome of patient satisfaction. Eight hundred (800) patient visits to the walk-in clinic of the Children's Hospital of Los Angeles were studied via tape recording of the doctor-patient interaction and by follow-up interview. Seventy-six percent (76%) of the patient visits resulted in satisfaction, as interpreted by the patients' mothers; in 24%, there was dissatisfaction. The study concluded that communication barriers that contributed to patient dissatisfaction included lack of warmth and friendliness by the doctor, failure to acknowledge the patient's concerns and expectations

[82] Barbara M. Korsch, Ethel K. Gozzi, and Vida Francis, "Gaps in Doctor-Patient Communication: Doctor-Patient Interaction and Patient Satisfaction," *Pediatrics* 42, no. 5 (November 1968): 855-871.

of the medical visit, and lack of clear, concise communication regarding diagnosis and treatment.[83]

From July 1990 – February 1992, Simon et al.[84] conducted a study at Brigham and Women's Hospital to determine how physician-patient communication varied with and without PCP involvement. Consecutive patients hospitalized with chest pain (n=1059) were surveyed. The results showed that those patients whose PCPs continued to be involved in hospital care were less likely to report ineffective communication regarding their care including: issues regarding tests (20% vs 31%, p = 0.03), activity after discharge (42% vs 51%, p = 0.02), and health habits (31% vs 38%, p = 0.07). If a hospitalist was not used, communication problems by patients were less frequently reported. Because PCPs already were conversant with their patients' personalities and histories, there were fewer communication issues, and the hospitalized patients were more receptive to communication from their regular physician. Efforts to improve physician-patient communication should be a priority to enhance or maintain patient satisfaction.[85]

A summary of outcome studies, complied by Wachter and Goldman,[86] revealed that patients cared for by hospitalists demonstrated satisfaction rates no lower than that of

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[83] Korsch, Gozzi, and Francis, 869.

[84] Steven R. Simon et al., "Communication Problems for Patients Hospitalized with Chest Pain," *Journal of General Internal Medicine* 13 (December 1998): 836-838.

[85] Simon et al., 838.

[86] Robert M. Wachter and Lee Goldman, "The Hospitalist Movement Five Years Later," *Journal of the American Medical Association* 287, no. 4 (January 23, 2002), 487-494.

patients cared for by their PCPs. The studies were conducted from 1998 to 2001 at various facilities throughout the United States. In addition to satisfaction, other outcomes including costs and average lengths of stay were determined. Davis et al.[87] conducted a comparison study of patient outcomes (i.e., length of stay, cost of care, patient satisfaction, and 30 day readmission). They compared patients that were treated by hospitalists with those treated by internists at a 647-bed rural community hospital (n = 443). The results revealed that patients treated by hospitalists had a shorter mean length of stay ($p < 0.001$), and their cost of care was less than that of patients treated by internists ($p < 0.001$). Patient satisfaction was similar for both groups regarding ability to keep patient and family informed ($p = 0.67$); physician courtesy and friendliness ($p = 0.87$); or physician and staff ability to work together ($p = 0.30$). More than 95% responded "good," "very good" or "excellent" to those questions.[88]

In a cross-sectional questionnaire study (n = 85) by Hruby, Pantilat, and Lo,[89] communication among patients, PCPs, and inpatient physicians was evaluated by patients (n = 73), or, if the patients were too sick, by their relatives (n = 12). These patients or relatives were surveyed by the study team on topics including relationship with PCPs, contact with PCPs, knowledge of inpatient physician, and communication between PCPs and inpatient hospital physicians. Eighty-five (85) patients were included in the study.

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[87] Kenneth M. Davis et al., "Effects of Hospitalists on Cost, Outcomes, and Patient Satisfaction in a Rural Health System," *The American Journal of Medicine* 108 (June 1, 2000): 622.

[88] Davis et al., 623.

[89] Milena Hruby, Steven Z. Pantilat, and Bernard Lo, "How do Patients View the Role of the Primary Care Physician in Inpatient Care?" *The American Journal of Medicine* 111, issue 9, S2 (December 21, 2001): 21-25.

Eighty-seven percent (87%) had a PCP, and 33% of these patients had contact with their PCP while in the hospital. Sixty-one percent (61%) were aware that communication occurred between their PCP and hospital physician. Fifty percent (50%) of the participants believed that their PCP should inform them of serious diagnoses rather than the inpatient physician. The investigators concluded that methods should be in place to facilitate communication among patients, inpatient physicians and PCPs, in order to maintain continuity of care.[90]

In 2006, O'Leary, Liebovitz, and Baker[91] conducted a time-motion study to determine how hospitalists allocate their time. The study demonstrated that hospitalists spent a large amount of time on communication, when compared to non-hospitalist physicians. The hospital environment required multi-tasking and frequent interruptions. These distractions can hinder communication interactions and lead to errors. Several years later, Tipping, Forth, O'Leary, Malkenson, Magill, Englert, and Williams[92] further evaluated the roles of hospitalists with a time-motion study. The results showed that hospitalists spent time on direct patient contact (17.0%), indirect patient care (64.0%), and (19.0%) on professional development, travel, personal, and wait times. For 16.0% of all time recorded, multi-tasking was occurring. Hospitalists with above average patient loads spent less time per patient communicating with others and working with the EMR

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[90] Hruby, Pantilat, and Lo, 21-22.

[91] Kevin J. O'Leary, David M. Liebovitz, and David W. Baker, "How Hospitalists Spend Their Time: Insights on Efficiency and Safety," *Journal of Hospital Medicine* 1, no. 2 (March/April 2006): 88-93.

[92] Matthew D. Tipping et al., "Where Did the Day Go? – A Time-Motion Study of Hospitalists," *Journal of Hospital Medicine* 5, no. 6 (July/August 2010): 323-328.

than those hospitalists with below-average patient loads and they reported delayed documentation until later in the evening or next day. Patient load did not change the amount of time hospitalists spent with each patient. More of hospitalists' time was spent working with the EMR than directly with the patient. Twenty-six percent (26.0%) of hospitalists' time was spent on communication, including various electronic means and interaction with other professionals. Effective communication skills remain an area for development and improvement.

Rothberg and associates[93] conducted a time-motion study with a cross-sectional survey to assess the association among three areas: time spent communicating, agreement on plan of care, and patient satisfaction. A stopwatch was utilized by the investigators to document the amount of time hospitalists spent on communication. Physician-nurse agreement on the plan of care and patient satisfaction were assessed via survey. Eighteen (18) hospitalists caring for 379 patients were observed by the investigators. The results demonstrated that hospitalists varied in the amount of time communicating, but there was no association between time spent and patient satisfaction or agreement on plan of care.[94]

More recently, a pre-intervention versus post-intervention comparison of patient satisfaction scores was conducted by O'Leary, Darling, and Rauworth[95] at a non-teaching

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[93] Michael R. Rothberg et al., "The Relationship between Time Spent Communicating and Communication Outcomes on a Hospital Medicine Service," *Journal of General Internal Medicine* (September 16, 2011): 185-189.

[94] Rothberg et al., 185.

[95] Kevin J. O'Leary, Tiffani A. Darling, Jennifer Rauworth, and Mark V. Williams, "Impact of Hospitalist Communication-Skills Training on Patient-Satisfaction Scores," *Journal of Hospital Medicine* 8, no.6 (June 2013): 315-320.

hospitalist service in an urban academic hospital. The intervention was a three-session communication skills training program for hospitalists. The study used a third-party vendor, Press Ganey Associates, Inc., and HCAHPS survey scores to evaluate patient satisfaction, which did not significantly improve after a communication skills training program for hospitalists. The results of this study should be considered when planning strategies and interventions to improve physician communication skills.

Fulton, Drevs, Ayala, and Malott[96] examined patient satisfaction with hospitalist communication in a cross-sectional study. Data from 2,648,275 patients in 1,777 hospitals (41% of which employed hospitalists) in 2008 were studied using Press Ganey's patient satisfaction survey. Findings suggested that hospitalist facilities may have an advantage over non-hospitalist institutions regarding communication-related satisfaction issues. In addition, large facilities and teaching hospitals may especially benefit from the presence of hospitalists.

Zolnierek and DiMatteo[97] conducted a meta-analysis of published literature (1949-August 2008) on physician communication and patient adherence to treatment regimens. One hundred and six (106) correlational studies and 21 experimental interventions were reviewed. Zolnierek and DiMatteo found that "physician communication is significantly positively correlated with patient adherence; there is a 19.0% higher risk of non-adherence among patients whose physician communicates

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[96] Bradley R. Fulton, Kathryn E. Drevs, Louis J. Ayala, and Donald L. Malott, "Patient Satisfaction with Hospitalists: Facility-Level Analysis," *American Journal of Medical Quality* 26, no. 2 (March/April 2011): 95-102.

[97] Kelly B. Haskard Zolnierek and M. Robin DiMatteo, "Physician Communication and Patient Adherence to Treatment: A Meta-analysis," *Medical Care* 47, no. 8 (August 2009): 826-834.

poorly than among patients whose physician communicates well."[98] Better communication can improve clinical outcomes and patient adherence to treatment plans.

In 2009, Chen and associates[99] conducted a retrospective cohort study on hospitalist care and patient satisfaction. Utilizing information from Medicare Provider Analysis and Review File, as well as patient satisfaction as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, they compared "non –hospitalist" hospitals (median of 0% of general medicine patients cared for by hospitalists), "mixed-hospitalist" hospitals (median of 39.5% of general medicine patients cared for by hospitalists), and "hospitalist" hospitals (median of 76.5% of general medicine patients cared for by hospitalists). The study reported that "hospitalist" hospitals had better performance on global measures of patient satisfaction than "mixed" or "non-hospitalist" hospitals (overall satisfaction 65.6% vs 63.9% vs 63.9% respectively, $p < 0.001$).

Patient satisfaction with hospital care provided by hospitalists vs. PCPs was also researched by Seiler, Visintainer, Brzostek, Ehresman, Benjamin, Whitcomb, and Rothberg. [100] Between 2003 and 2009, random patient satisfaction telephone interviews were conducted on discharged patients from three Massachusetts hospitals. Recently

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[98] Zolnierek and DiMatteo, 826.

[99] Lena M. Chen, John D. Birkmeyer, Sanjay Saint, and Ashish K. Jha, "Hospitalist Staffing and Patient Satisfaction in the National Medicare Population," *Journal of Hospital Medicine* 8, no. 3 (March 2013): 126-131.

[100] Adrianne Seiler et al., "Patient Satisfaction with Hospital Care Provided by Hospitalists and Primary Care Physicians," *Journal of Hospital Medicine* 7, no. 2 (February 2012): 131-136.

discharged patients completed surveys for 8,295 encounters with 3,597 hospitalists and 4,698 PCPs. HCAHPS survey was used to evaluate satisfaction. Multivariate adjusted satisfaction scores for physician care quality were slightly higher for PCPs than hospitalists (4.24 vs 4.20, $p = 0.04$); patient rating of hospitalists and PCPs for behavior, pain control, and communication were equivalent ($p > 0.23$). The overall conclusion was that patients appear similarly satisfied with care provided by hospitalists and PCPs.[101]

Study Tool

Assessment of communication techniques and skills is an important part of self-evaluation. In the practice of medicine where physicians are interacting with patients, families, and other health care professionals, communication skills need to be exceptional. Evaluation of one's communication should be performed intermittently to identify areas of improvement. The tool utilized for this study was modified from the original Communication Assessment Tool (CAT) developed by Gregory Makoul (see Appendix E).

The CAT was developed to assess interpersonal and communication skills of physicians. To determine validity and reliability, the CAT was administered to 950 patients, or their caregivers, under the care of 38 physicians from various specialties (dermatology, family medicine, neurosurgery, ophthalmology, orthopedic surgery, and physical medicine and rehabilitation). Patients completed the CAT within one day of their office visit. More than half (55.8%) of patients or caregivers used the telephone

[101] Seiler et al., 131.

version of the tool, while 44.2% went online to complete the CAT. The average patient-reported mean score per physician was 4.68 (SD = 0.54, range 3.97- 4.95) across all CAT items. The average proportion of excellent scores was 76.3% (SD = 11.1, range 45.7-95.1%). Overall scale internal consistency reliability was high (Cronbach's alpha = 0.96).[102] Validity testing was performed using an existing patient satisfaction tool to compare with CAT scores. Comparison was done for three physicians with the lowest patient satisfaction scores and three physicians with the highest patient satisfaction scores from the pre-existing tool. The CAT ratings were markedly different between the groups: the lowest patient satisfaction group had a CAT rating of 4.28 (S.D. = 0.67) and the highest patient satisfaction group had a CAT rating of 4.92 (S.D. = 0.23). The CAT survey was found to be valid. This field test established that the CAT can be successfully utilized by patients treated by physicians from a wide variety of clinical specialties. Reporting the proportion of excellent ratings given by patients was found to be more useful than summarizing via mean scores. By reporting only the percentage of excellent scores, physicians can clearly see areas for improvement.[103]

The integrity of the CAT is further supported by a study conducted by Myerholtz and colleagues.[104] The study utilized the CAT in family medicine residency programs to gather initial benchmarking data to determine its usefulness in family residency

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[102] Gregory Makoul, Edward Krupat, and Chih-Hung Chang, "Measuring Patient Views of Physician Communication Skills: Development and Testing of the Communication Assessment Tool," *Patient Education and Counseling* 67, no. 3 (August 2007): 333.

[103] Makoul, Krupat, and Chang, 339.

[104] Linda Myerholtz et al., "Using the Communication Assessment Tool in Family Medicine Residency Programs," *Family Medicine* 42, no. 8 (September 2010): 567-573.

programs. Data were collected from 1,931 patients under the care of 127 residents from six family medicine residency programs. The patients completed the pencil-and-paper version of the CAT. The overall mean percentage of items rated as "excellent" was 69.7%. Significant differences were found in the overall percentage of items rated as "excellent" based on training year: PGY-1 (77%), PGY-2 (69.5%) and PGY-3 (68.1%). The item with the highest percentage of excellent responses was "Paid attention to me" (73.6%), and the item with the lowest-rated percentage of excellent responses was "encouraged me to ask questions" (63.2%). The CAT was found to be useful as an evaluative and learning tool in family residency programs.[105]

In other research utilizing the CAT, Ferranti et al.[106] conducted a cross-sectional study of adult patients admitted to the hospital medicine service at an urban academic medical center with 873 beds. Thirty-five (35) hospitalists were evaluated. Seven hundred (700) patient surveys were completed (20 for each hospitalist). The proportion of excellent ratings for each hospitalist ranged from 38.5-73.5%, with an average of 59.1% excellent (S.D. = 9.5). The items that received the highest percentage of excellent responses included "treating me with respect" and "letting me talk without interruptions" (66.3%). The item that received the lowest percentage of excellent responses was "involved me in decisions as much as I wanted" (52.9%). The CAT can be used to assess

[105] Myerholtz et al., 567.

[106] Darlene Ferranti et al., "Assessing Patient Perceptions of Hospitalist Communication Skills Using the Communication Assessment Tool (CAT)," *Journal of Hospital Medicine* 5, no. 9 (November/December 2010): 522-527.

patient perceptions of hospitalist communication skills. Overall scale reliability was high (Cronbach's alpha = 0.97).[107]

The CAT, which was developed to evaluate individual physicians, was modified by Makoul to assess the medical team. Adaptations to the CAT included modified instructions and item-stems that broadened the scope from "Your doctor" to "Your medical team." In addition, "The doctor's staff" was revised to "The front desk staff." A prospective, cross-sectional pilot study using the Communication Assessment Tool – Team (CAT-T) was undertaken by Mercer et al. in an urban academic Level 1 trauma center. Eligible adult patients (i.e., $\geq$ 18 years of age, no primary psychiatric issues, not critically ill or physiologically unstable, English-speaking, and not under arrest) in the ER were given the CAT-T to complete. One hundred and five (105) patients were screened; 81 patients were enrolled. The items receiving the highest percentage of excellent responses (69.0%) were for "treating me with respect," "paying attention to me," and "showing care and concern." The items with the lowest percentage of excellent responses were received in "showing interest in my ideas about my health" (53.0%) and "involving the patient in decisions as much as I wanted" (53.0%). The study demonstrated that patient assessment of communication with a medical team is feasible.[108]

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[107] Ferranti et al., 522.

[108] Mercer et al., 220.

McCarthy et al. [109] conducted a cross-sectional study in an urban academic emergency department using the CAT-T in 2012. Three hundred forty six (346) patients were eligible and 265 enrolled; however, the final sample only included 226 patients for analysis after 39 patients were excluded due to missing data. The tool was administered via verbal interview with the research assistant. The scores on the CAT-T items rated as "excellent" ranged from 50.0%-76.1%. The item with the highest number of excellent scores was "let me talk without interruptions" (76.1%), and the item with the lowest number of excellent scores was "encouraged me to ask questions" (50.0%). There were no associations between patient demographic factors such as, age, gender, and ethnicity, and patient perceptions of communication.

Significance

The need for hospitalists in the tertiary care setting persists and there continues to be a growing number of professionals who specialize in hospitalist medicine. There is no indication in the literature that the use of hospitalists in acute care will decrease. To be successful in the hospitalist model, effective communication with patients and their PCPs must be a priority. Patients in the acute care setting must feel confident that their medical care is not only being soundly managed by hospitalist specialists but is also being effectively communicated to themselves, their families, and their PCPs with whom they already have an established relationship.

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[109] Danielle M. McCarthy et al., "Emergency Department Team Communication with the Patient: The Patient's Perceptive," *Journal of Emergency Medicine* 45, no. 2 (February 20, 2012): 262-269.

The nature of hospitalist medicine requires timely and accurate communication; delayed communication can adversely impact patient care and satisfaction.[110] Patient satisfaction with hospitalists will increasingly influence a health system's ratings and rankings by objective third parties, such as HCAHPS as well as authorized private vendors. Many health care facilities utilize private vendors to assist with collection, collation, and distribution of patient satisfaction results.

HCAHPS is the first national, standardized, publically reported survey of patients' feedback on the frequency of communication with them by health care staff and the quality of their care.[111] HCAHPS states,

> The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. While many hospitals have collected information on patient satisfaction, prior to HCAHPS there was no national standard for collecting or publicly reporting patients' perspectives of care information that would enable valid comparisons to be made across all hospitals.[112]

HCAHPS surveys ask patients to rate their hospital experiences based on their inpatient admission stay (see Appendix F). These patient ratings are collated and publicized. The publication of such results can impact a hospital's reputation, potentially affecting the number of future admissions to the facility. Positive HCAHPS scores can be used as a marketing tool for hospitals to expand their services. HCAHPS results also directly impact a hospital's reimbursement from the Centers for Medicare and Medicaid Services (CMS). The old "fee-for-service" Medicare, which is driven by the volume of

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[110] Kripalani et al., 831.

[111] HCAHPS, http://hcahpsonline.org/home.aspx (accessed February 4, 2015).

[112] HCAHPS, http://hcahpsonline.org/home.aspx (accessed April 19, 2014).

patients seen by physicians, is slowly being transitioned to an emphasis on quality of care. Simply stated, payment is based on the quality of care delivered, not number of patients treated. Quality is evaluated by patient surveys, facility surveys, and site visits.

HCAHPS provides yet another dimension to hospitals regarding information on patient satisfaction. As with any other profession, the health care industry has competition amongst health care facilities. Facilities are striving to provide the best care to patients. Hospitals want to have satisfied patients who will continue to choose to use their hospital. Meeting the highest standards and achieving the highest scores of HCAHPS are the focus of many hospitals. In addition to the information hospitals collect, HCAHPS survey data are used to guide internal customer service and quality improvement projects.[113] Customer service and care excellence are priorities for all health care facilities. Results from surveys are available to the public online, thereby compounding the importance of meeting the goals of high patient satisfaction. In addition, physicians' professional fees and hospitals' reimbursements from CMS will depend on the scores received from their patients. A percentage of CMS reimbursement to facilities will be tied to scores received on HCAHPS. Positive HCAHPS scores could mean a financial windfall for hospitals that achieve high scores due to highly satisfied patients.

As previously discussed, patients' satisfaction with the hospital experience is routinely evaluated after discharge. Hospitals frequently use the services of independent third parties to collect and conduct post-discharge patient surveys. Press Ganey

[113] HCAHPS, http://hcahpsonline.org/home.aspx (accessed April 19, 2014).

Associates, Inc., the company that this study site uses, is a corporation that solicits satisfaction information from patients and families. Press Ganey assists in the quest to deliver high-quality care by evaluating the patient's experience and recommending improvements.[114] Through surveys, patients are able to rate their satisfaction with the hospital experience as well as their experience with doctors and nurses.

Press Ganey Scores for Patient Satisfaction Improvement are important evaluation tools for health care facilities. Press Ganey, or another third party that measures patients' hospital experiences, assists hospitals in preparing for HCAHPS surveys. They identify areas of improvement to enhance patient experiences.

There are initiatives that are specifically related to physician quality care and reimbursement. One such program is the Physician Quality Reporting System (PQRS). This program applies "incentive payments and negative payment adjustments to promote reporting of quality measures by physicians."[115] A goal of the PQRS program is to reward physicians who achieve high-quality care. The current focus is on value-driven health care instead of the old fee-for-service reimbursement system.[116] Hospitalists can promote and support the quality measures that are associated with the acute care setting—for example, medication reconciliation and deep vein thrombosis prophylaxis for certain medical conditions. Hospital-acquired conditions will no longer be paid for by

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[114] Press Ganey Associates, Inc., http://www.pressganey.com/aboutUs/ourMission.aspx (accessed April 5, 2014).

[115] Centers for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/ (accessed March 19, 2015).

[116] Patrick H. Conway, "Value-Driven HealthCare: Implications for Hospitals and Hospitalists," *Journal of Hospital Medicine* 4, no. 8 (October 2009): 507.

CMS; hospitalists are on the front lines in the care delivered in hospitals; therefore, they should be involved in reducing the number of non-reimbursable hospital-acquired conditions.[117]

National Patient Safety Goals (NPSGs) are standards promoted by the Joint Commission (JC) and exist to provide patients with the safest care possible in the acute-care setting (see Appendix G). Hospitals strive to meet these quality guidelines and promote their accomplishments to the community. One such standard involves improvement in staff communication. The standard encompasses getting important test results to the right staff person on time and states in part, "critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated."[118] The hospitalist model with 24-hour coverage addresses this standard. Laboratory and diagnostic results can be interpreted and managed by hospitalists because they are frequently "in-house" and available 24/7. Previously, PCPs would return to the hospital after office hours or the next day to retrieve diagnostic findings. This delay in treatment could have prolonged a hospital stay and added to the cost of the hospitalization.

Because effective communication is an essential part of medicine, medical education is placing therapeutic communication in a prominent position in its

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[117] Conway, 508.

[118] Joint Commission, http://www.jointcommission.org/standards_information/npsgs.aspx (accessed April 7, 2014).

curriculum.[119] This is especially important at teaching hospitals where residents provide care to patients and can function in the hospitalist role during their training. Hospitals and residents must meet established regulatory guidelines. The Accreditation Council for Graduate Medical Education (ACGME) provides regulatory guidance and standards to residency programs. This organization was established in 1981 because of an identified need in the medical community for an organization that would independently provide accreditation for graduate medical education programs.[120] The ACGME recognizes the importance of interpersonal and communication skills by including them as one of its six competencies in Graduate Medical Education (GME). The ACGME developed competencies that residents must satisfy to complete their residency training successfully. These competencies reflect, "specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs."[121] The six competencies include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.[122]

The interpersonal and communication skills, which are measured by the ACGME via demonstration and observation, involve all aspects of the patient-family interaction.

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[119] Gregory Makoul, "The Interplay Between Education and Research About Patient- Provider Communication," *Patient Education and Counseling* 50 (May 2003): 80.

[120] ACGME, http://www.acgme.org/acgmeweb/tabid/116/About.aspx (accessed April 5, 2014).

[121] ACGME, http://www.acgme.org/acgmeweb/tabid/116/About.aspx (accessed April 5, 2014).

[122] ACGME, http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf (accessed April 5, 2014).

"Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals."[123] The competency outcomes are further stated: "Residents are expected to communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds along with other health professionals, and health-related agencies."[124] Communication and interpersonal skills also involve the role of functioning as a team leader and as consultant to other physicians and health care professionals.[125] These competencies must be met by residents for the successful completion of training. The successful demonstration of a resident's communication skills should carry over and be embedded in his/her medical practice after medical school.

The general ACGME competencies have been endorsed by the American Board of Medical Specialties (ABMS), the certifying board for physicians. As per its website, the ABMS focus is on improving the quality of health care to patients, families, and communities by supporting the continuous professional development of physician specialists. Physicians meet standards and competencies in professionalism, patient care and procedural skills, medical knowledge, practice-based learning, interpersonal and

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[123] ACGME, http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf (accessed April 5, 2014).

[124] ACGME, http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf (accessed April 5, 2014).

[125] ACGME, http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf (accessed April 5, 2014).

communication skills, and systems-based resources to maintain their medical certification.[126] From residency, communication is an integral part of physician practice.

Regulations and guidelines, which are present to support and provide good, safe patient care, will continue to be important forces that guide hospitals in improving patient outcomes. As hospitals attempt to meet quality measures, emphasis on communication will be paramount. More recently, reimbursement from CMS has been correlated with patients' satisfaction with care. This study provides a needed assessment of patients' experiences in relation to communication from hospitalists.

The values of Drew University's Medical Humanities Program are threaded throughout this research. The program accentuates the dynamic of the doctor-patient relationship. Hospitalist medicine alters the traditional doctor-patient relationship, which can lead to ethical concerns. Throughout the relationship, sensitive personal issues are addressed, which may include end-of-life wishes and care directives.

The discussions and interactions may be lost when care is discontinued from PCPs and transferred to hospitalists, to the detriment of patient autonomy and confidentiality. [127] Trust must be maintained for the hospitalist model of care to be successful. Honest and open communication is the foundation of effective and caring

[126] American Board of Medical Specialties (ABMS), http://www.abms.org/about-abms/ (accessed February 1, 2015).

[127] "The traditional patient-primary care physician (PCP) relationship provides many ethical protections for patients, including confidentiality, shared medical decision-making, and respect for patient autonomy. Hospitalist models, which introduce a purposeful discontinuity of care, threaten these protections and raise certain ethical concerns." Pantilat, Alpers, and Wachter, 171.

relationships between physicians and patients.[128] Hospitalists must establish and maintain open lines of communication and develop a rapport to support and preserve a therapeutic patient relationship.

Because reimbursement is linked to communication, it is likely that evaluation and assessment of communication will continue to be at the forefront of hospitals' agendas. Currently, communication and satisfaction remain measurable outcomes for residency education programs, national regulatory agencies, and consumer advocacy groups.

Over the years, many studies have been conducted to evaluate communication and patient satisfaction. While satisfaction with communication between hospitalists and patients has been studied and reported in the literature, few, if any, studies have examined predictors of satisfaction. Further, there is no overwhelming consensus about hospitalists and their patients' satisfaction.[129] The present study was designed to generate new knowledge on patient satisfaction with hospitalist care by examining the association between satisfaction and length of stay, duration of relationship with PCPs, and medical or surgical diagnostic category. The results of this study may be used to help in the design of interventions that will enhance communication between patients and providers.

Poor communication can create a lack of trust, which can lead to increased potential for lawsuits as well as impersonal care. Ineffective communication can be

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[128] David Mechanic and Mark Schlesinger, "The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians," *Journal of the American Medical Association* 275, no. 21 (June 5, 1996): 1695.

[129] Fulton et al., 95.

interpreted as care that lacks humanity. When the patient's medical narrative is not communicated properly, there can be an increased potential for seeking second opinions; this may lead to increases in health-related costs and poor compliance with the plan of care. "Patient-doctor communication and patient adherence are inexorably linked because the interaction provides the context which the recommendations to be complied with are delivered."[130] Poor compliance leads to poor outcomes. If patients do not view hospitalists as experts, patients can develop a lack of respect and trust in the providers.

Poor communication can lead to expensive medication errors. Devastating consequences can occur when misinformation is given regarding current medication regimen and allergies. When care is handed off as it is with hospitalist medicine, one needs to question the accuracy of information from patients. By not having an established relationship with patients, hospitalists are at a disadvantage by not knowing the complete medical history. Hospitalists at times make decisions based on minimal/inadequate information; this can be disastrous. Treating patients incorrectly or insufficiently can lead to repeat admissions to the hospital, thereby increasing total health care costs.

There is value to conducting an assessment of communication techniques. Physician self-awareness of the areas that need improvement will enhance therapeutic interactions. The goal is to improve outcomes and increase the safety of patient care as well as patient satisfaction.

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[130] Moira Stewart et al., "Evidence on Patient-Doctor Communication," *Cancer Prevention and Control* 3, no 1 (February 1999): 27.

Research Tool

To assess communication skills of hospitalists in this study, a survey was administered to patients permitting them to rate the skills of their hospitalists. Gregory Makoul, Ph.D. developed the CAT-T which has been found to be "a reliable and valid instrument for measuring patient perceptions of physician performance in the area of interpersonal and communication skills."[131] The CAT-T is a survey in which patients rate the communication techniques of their medical team. The CAT-T has been modified for this study (see Appendix H).

Hypotheses

The focus of this research is on patients' perception of communication between themselves and the hospitalist team managing their care. The CAT-T was used to assess how satisfied patients are with communication between themselves and their hospitalist(s). The study will evaluate 4 hypotheses:

- The first hypothesis predicts that patients who report more excellent communication experiences with the hospitalist team will be more satisfied with the quality of their medical care.
- Hypothesis two states that patients without a PCP will report more interactions as excellent from their hospitalist(s) than those with a PCP.
- The third hypothesis proposes that patients who interact with more than one hospitalist will rate more interactions less than excellent.

[131] Makoul, Krupat, and Chang, 333.

- Hypothesis four predicts a negative association (inverse relationship) between length of stay and satisfaction; a longer length of stay will be associated with fewer interactions rated as “excellent” by patients.

The results of the present study may have important clinical implications. These data may be used to inform administrative policy and clinical interventions that will improve patient-provider communication and satisfaction with care.

Chapter Two

Methods

> Whatever words we utter should be chosen with care for people will hear them and be influenced by them for good or ill.
> ——— Buddha

Study Site

This descriptive, comparison study was conducted at a tertiary care institution in northern New Jersey. The hospital is a not-for-profit, level 1 regional trauma center. The facility has over 650 patient beds, approximately 6,000 employees, including 1,800 nurses, and over 1,400 physicians. The institution is a teaching hospital, which provides education and training to approximately 200 residents annually. The study site reports slightly less than 40,000 admissions per year. The majority of patients admitted to the institution are receiving care and medical management by hospitalists.

The institution endorses hospitalist medicine as a method of care delivery within the facility. The hospitalists strive to provide around-the-clock patient-centered care and service, thorough communication with patients and families, and the highest quality of care.[132]

The study site functions with a voluntary hospitalist system. If preferred, PCPs may admit their own patients; however, the hospital also employs its own hospitalists to

[132] Atlantic Health, http://www.atlantichealth.org/morristown/the+patient+experience/hospital+stays/hospitalist+program (accessed March 11, 2015).

provide patient care when needed. Private practice hospitalists that have an established agreement with PCPs to admit and manage hospitalized patients are also on the medical staff of the hospital. These varied approaches to the delivery of medical care, provide PCPs with several options in management of their hospitalized patients.

The CAT-T survey was administered to adults on the cardiac, oncology, orthopedic, and general medical and surgical floors. These floors house the majority of adult patients under the care of hospitalists. It was not planned to administer the CAT-T to patients in the critical care areas due to the acute nature of patient conditions and the low probability that patients would be discharged within 48 hours.

Participants

The patients surveyed for this research were being managed by a third-party, which provides hospitalist medical services to tertiary care and sub-acute facilities throughout the nation. This hospitalist group is one of several used by the facility. Currently, the group practices within 27 states and annually manages the care of over one million patients. There are a total of 10 physicians and 2 physician assistants practicing at the study site. This practice was chosen for the study because it is the largest group providing hospitalist care at the study site.

The study was presented to the hospitalists at their monthly staff meeting by the Principal Investigator (PI). Nine physician hospitalists as well as two physician assistants and various hospital representatives were in attendance at the meeting. The physician not in attendance was presented with information regarding the study by the PI at a later date. If in agreement to permit their patients to participate, hospitalists signed a statement (prior to the PI meeting patients) which would allow the PI to approach their patients

about the study (see Appendix I). Nine of the hospitalists were approached and agreed to support the study by allowing the PI to interview their patients.

Inclusion and Exclusion Criteria

Consenting patients under the care of participating hospitalists were eligible to join the study. Additional inclusion/exclusion criteria included:

Inclusion: All adults age 18 or greater with an anticipated discharge date within 48 hours of the interview. Inclusion criteria included the ability to read and write English.

Exclusion: Medically unstable and/or unable to read or write English. Decisionally-impaired individuals. Patients who could not identify their hospitalist(s).

Institutional Review Board

Institutional Review Board (IRB) approval was obtained from the Atlantic Health System Institutional Review Board (see Appendix J). Since the responses do not collect personal health information, there was no need for patients to complete and sign an informed consent. An Amendment/Modification Form for the IRB was also completed when it was determined that question "Treated me with Respect" could not be asked to avoid conflict with the Press Ganey patient satisfaction survey (see Appendix K).

Measures

Gregory Makoul, Ph.D. originally developed a Communication Assessment Tool (CAT), which is designed to evaluate the patient's perceptions on an individual

physician's communication effectiveness. The tool was later modified to ascertain patient satisfaction with communication from a medical team (Communication Assessment Tool – Team (CAT-T). The CAT-T survey tool is designed to document and interpret how patients feel about the communication between themselves and their medical team.

The CAT-T was utilized in this study to assess patients' perception of communication with their hospitalist(s) team. Patients may see various hospitalists during their admission. The study purpose was not to rate each individual physician but to rate the "team" of hospitalists rendering care. Therefore, the CAT-T was used instead of the CAT. When surveying patients, the PI defined the "Medical Team" to include only the hospitalist group. It was further clarified that the study was not intended to rate other hospital staff which included nurses, technician, or any ancillary services.

The original CAT-T, as developed by Makoul, is an instrument that can be utilized to assess the skills of residents and practicing physicians.[133] The original CAT-T has 14 core communication items that evaluate communication of the medical team, 1 item that addresses the front desk staff, as well as a question that asks patients to rate the care provided by the medical team (see Appendix E). Patients were requested to rate the hospitalist team on a one-to-five scale, wherein a value of 1 = poor; 2 = fair; 3 = good; 4 = very good; and 5 = excellent.

The CAT-T was modified for this study to properly measure the stated study hypotheses and meet revisions imposed by the study site (see Appendix H). The modified CAT-T is a survey in which patients rate the communication techniques of hospitalists (13 questions) and overall care (1 question). The following modifications were made:

- "Treated me with respect" (question 2 on the CAT-T) was not asked as it is identical to the question asked by Press Ganey Associates, Inc. Press Ganey's

[133] Makoul, Krupat, and Chang, 333.

survey is administered once patients are discharged from the hospital. At the request of the study site, to avoid influencing patients' responses on the Press Ganey survey, the question was deleted from the survey. This change was a modification to the original IRB approval and required an Amendment/Modification form to be completed prior to data collection (see Appendix K).

- The question regarding the "front desk staff" (question 15 on the CAT-T) was not included as it does not apply to this study.
- "How would you rate the care provided by your medical team?" was modified to reflect the hospitalist team. "How would you rate the care provided by your hospitalist team?" was asked to evaluate patients' perception of overall care delivered by hospitalists.

Individual item scores represent the proportion of patients who assigned a score of "excellent" for each item. The overall score on the original CAT-T presents an average of the first 13 items on the survey. For this study, the overall score was based on 13 items as the question "Treated me with respect" was not asked. In summary, CAT-T questions that evaluate communication for this study are:

1. Greeted me in a way that made me feel comfortable
2. Showed interest in my ideas about my health
3. Understood my main health concerns
4. Paid attention to me (looked at me, listened carefully)
5. Let me talk without interruptions
6. Gave me as much information as I wanted
7. Talked in terms I could understand
8. Checked to be sure I understood everything
9. Encouraged me to ask questions
10. Involved me in decisions as much as I wanted
11. Discussed next steps, including any follow-up plans
12. Showed care and concern
13. Spent the right amount of time with me

In addition to rating communication utilizing the CAT-T questions, another question required patients to rate the care provided by the hospitalist team. "How would you rate the care provided by your hospitalist team?" was asked. This question was used to assess overall satisfaction with medical care. The same 5-point response scale as the other questions was used.

Page two of the CAT-T consists of demographic and clinical questions. The demographic questions included age, gender, and ethnicity. Minor modifications were done and additional clinical questions were asked to evaluate and analyze the study hypotheses. These changes included:

Modification

- "Have you seen this doctor before?" was clarified by changing to "Have you seen this hospitalist before?"

Additional questions

- "How well did your hospitalists inform you of their role?" The patient rated this item in a similar manner as the other CAT-T questions in the poor (1) – excellent (5) scoring range.
- "Do you have a Primary Care Physician? If yes, how long have you seen this PCP?" _____ years
- "In total, how many hospitalists have you interacted with during this admission?" Response choices are: 1, 1-3, 3-6, and 7 or more
- "How long have you been in the hospital?" Patients primarily supplied the answer to this question. If unable to recall or answer, the PI obtained the admission date from the hospitalist.
- Diagnosis: Medical or surgical was recorded by the PI.

Important to note is that the survey was only administered directly to patients as per IRB approval. Therefore, "Were you the patient today?" generated "yes" responses for 100% of the surveys.

Scoring

The overall score obtained for communication represents an average of the first 13 items on the survey. The score is based on the percentage of excellent responses. Evaluation of satisfaction with care was determined by the percentage of excellent responses for question "How would you rate the care provided by your hospitalist team?" In addition, individual item scores represent the proportion of patients who assigned a score of "excellent" for each item (1-13) on the CAT-T.

Data Collection

The PI went to each nursing unit and met with the hospitalist that was covering the unit each day, Monday through Friday. Seven days were needed to reach the desired sample size of 75. The hospitalist reviewed the patient census with the PI. All patients that met inclusion criteria were referred to the PI who then met with patients in their rooms and introduced the study. Patients were asked to confirm they knew who their hospitalist team was by viewing and identifying their hospitalists from a photo. (A brochure-type document which had photos of each of the hospitalists was shown to patients.) Patients were included if they could identify the photo of the hospitalist(s) caring for them.

After a brief discussion about the study, all questions were answered, and verbal consent was obtained from the patient. All surveys were administered directly to patients

by the PI. Family members or health care designees were not permitted to answer. Each patient was given a copy of the survey to review and read. As conducted previously by Ferranti et al.[134] and McCarthy et al.[135], the PI conducted a structured interview by reading each item to the patient; the patient verbally responded with a 1 – 5 rating. The PI recorded the patient's response on the survey tool. A notation was made on the study tool regarding nursing unit and primary admitting diagnosis category (medical or surgical) for statistical analysis.

Analysis

Descriptive statistics for all variables were computed. The Kruskal-Wallis test was used to determine if there were significant differences in median CAT-T scores for each question by age group, gender, ethnicity, lengths of stay, years with PCP, number of hospitalists seen, and whether there was a previously established relationship with the hospitalist. A multivariate linear regression model was performed to examine the contribution of each of the independent variables (demographic and clinical) to the outcome variable, total CAT-T score items 1 - 13. A Mann-Whitney U-test was applied to further analyze satisfaction with communication and lengths of stay. To examine the association between satisfaction with communication and medical care, Pearson correlations were computed.

[134] Ferranti et al., 523.

[135] McCarthy et al., 263.

Chapter Three

Results

Most people say that it is the intellect which makes a great scientist.
They are wrong: it is character.
—— Albert Einstein

Description of Sample

A total of 88 patients were referred to the study by the hospitalist team. Thirteen (13) were not enrolled. The breakdown of these patients includes: 4 patients refused participation, 4 patients were discharged prior to meeting with the PI, 2 patients were non-verbal, 1 patient could not understand the study or give verbal consent, and 1 was unable to identify her hospitalist. One patient stated, "I am not being discharged" and therefore was not included. One patient was asleep and another was off the floor having a procedure; however, both these patients were consented and enrolled the following day.

Therefore, 75 patients gave verbal consent and participated in the study. All patients had hospitalists managing their care. Patients surveyed met all inclusion criteria and no exclusion criteria. One hundred percent (100%) of survey items were answered by patients; no surveys were answered by a family member or health care proxy.

Daily enrollment numbers varied. The total enrollment per day was as follows, Day 1 = 9 subjects, Day 2 = 20 subjects, Day 3 = 2 subjects, Day 4 = 12 subjects, Day 5 = 10 subjects, Day 6 = 6 subjects, and Day 7 = 16 subjects. Analysis using the Kruskal-Wallis test regarding the day of week that the survey was administered did not reveal any statistically significant differences. In addition, there was no difference in median score based on when the survey was administered.

Although the study protocol stated that patients were anticipated to be discharged within 48 hours (as per the hospitalist), 9 patients (12.0%) were not discharged within that timeframe. Reasons for not being discharged within 48 hours included disposition issues and unresolved or new medical concerns. However, these patients were included in the study as the discharge plan was in place, and a relationship had been established with the hospitalist team.

Thirty-six (36) patients were male (48.0%); and 39 patients were female (52.0%) (see figure 1). The majority of patients fell into the age range of 65 - 84 (n = 45; 60.0%) One patient was < 24 years of age (1.33%), 3 patients were 25 - 44 (4.0%), 20 patients were 45 - 64 (26.67%), and 6 patients were > 85 (8.0%) (see figure 2). The majority of patients were Caucasian (n = 71; 94.67%). Two (2) patients were Hispanic (2.67%), 1 patient was American Indian (1.33%), and 1 was African American (1.33%) (see figure 3).

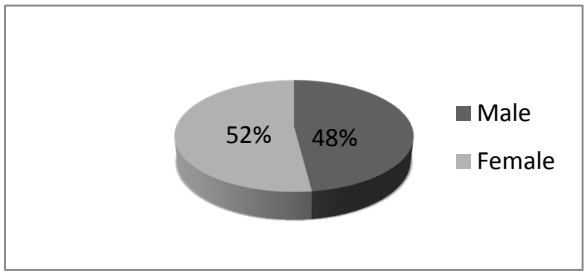

Figure 1: Gender distribution

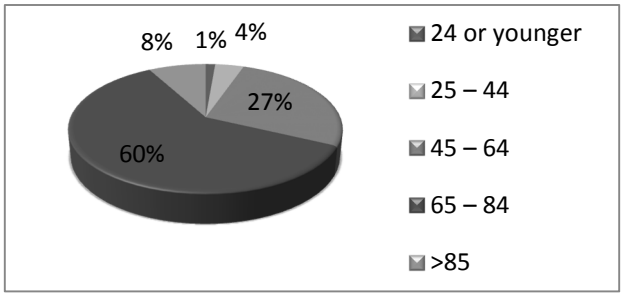

Figure 2: Age groups

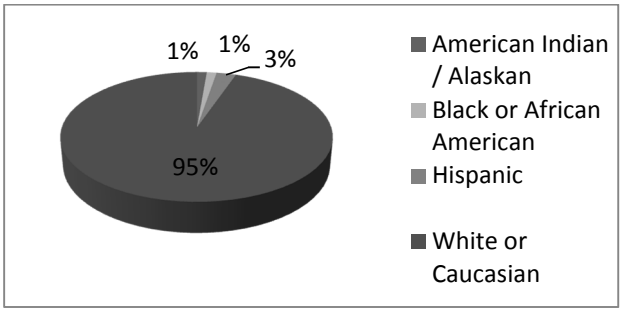

Figure 3: Ethnicity

Fifty-eight (58) patients (77.33%) had a primary diagnosis that was medically-related (for example: infections or cancer complications) and 17 patients (22.67%) had a surgically-related primary diagnosis (for example: orthopedic or heart surgery). Fifty-eight patients (58) (77.33%) had no past relationship with the study hospitalists, 10 (13.33%) reported seeing the hospitalists only once in a prior hospitalization, and 7 (9.33%) recalled seeing the hospitalists in more than one prior hospitalization. (see figures 4 and 5).

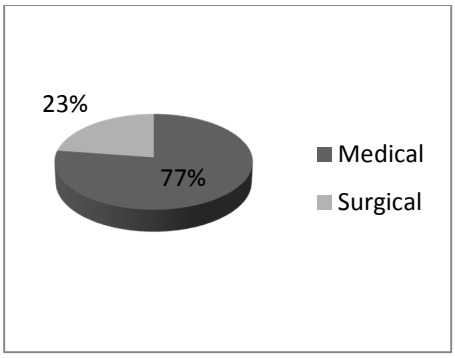

Figure 4: Diagnosis category

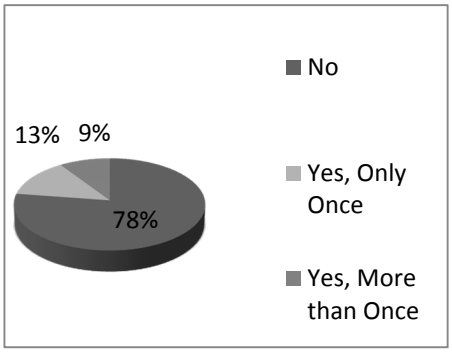

Figure 5: Past relationship with study MDs

In order to examine whether patients were informed of the reason for the hospitalists involvement with their care, the question "How well did the hospitalist inform you of their role?" was asked. Fifty-one (51) patients (68.0%) responded "excellent" (mean score = 4.41, median score = 5) when asked this question. There were no statistically significant findings when this question was analyzed with independent variables, both clinical and demographic, when using the Kruskal-Wallis test.

Because of an error in coding of the number of hospitalists seen (categories including overlapping numbers -- i.e., 1, 1-3, 3-6, 7 or more), the categorization was changed to one hospitalist and more than one hospitalist. This would likely not affect results since the majority of patients (n = 44; 58.67%) saw only 1 hospitalist (see figure 6).

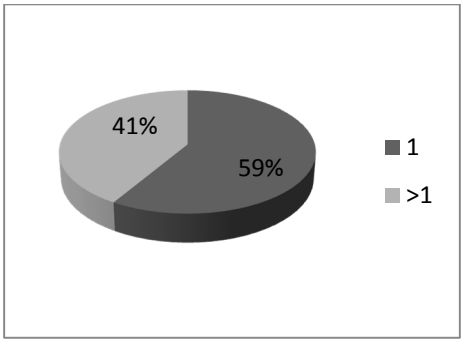

Figure 6: Percentage of hospitalists patients interacted with during admission

Sixty-nine (69) patients (92%) had a PCP, and 6 (8%) did not have a PCP prior to admission (see figure 7). Of the 69 patients with a PCP, 6 patients (8%) had been seeing their PCP 1 year or less, 15 patients (22%) had been seeing their PCP for 2-5 years, 15 patients (22%) had been seeing their PCP for 6-10 years, 15 patients (22%) had been seeing their PCP for 11-15 years, and 18 patients (26%) had been seeing their PCP for >16 years. Kruskal-Wallis tests to examine differences in satisfaction by duration of PCP relationship were not significant. Table 3.1 summarizes the demographic and clinical characteristics of the study population

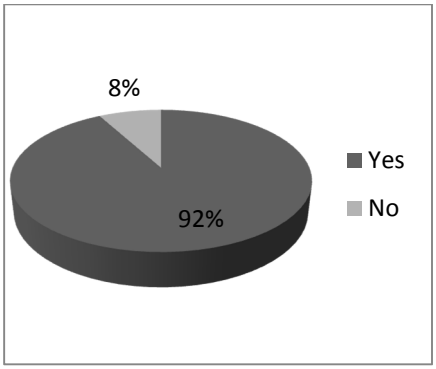

Figure 7: Percentage of patients with a PCP

Table 3.1: Characteristics of study participants

Variable	**Description**	**N (%)**
Age group	24 or younger	1 (1.33%)
	25 – 44	3 (4.0%)
	45 – 64	20 (26.67%)
	65 – 84	45 (60.0%)
	<85	6 (8.0%)
Sex	Male	36 (48.0%)
	Female	39 (52.0%)
Previously Interacted with Hospitalist?	No	58 (77.33%)
	Yes, Only Once	10 (13.33%)
	Yes, More than Once	7 (9.33%)
Ethnicity	American Indian / Alaskan	1 (1.33%)
	Asian or Asian American	0 (0%)
	Black or African American	1 (1.33%)

	Hispanic	2 (2.67%)
	Native Hawaiian	0 (0%)
	White or Caucasian	71 (94.67%)
	Other	0 (0%)
Primary Care Physician	Yes	69 (92.0%)
	No	6 (8.0%)
Number of Hospitalists Interacted With	1	44 (58.67%)
	1 - 3	29 (38.67%)
	3 – 6	2 (2.67%)
	7 or More	0 (0%)
Diagnosis	Medical	58 (77.33%)
	Surgical	17 (22.67%)
Lengths of Stay	1-3 days	19 (25.33%)
	4-6 days	25 (33.33%)
	7+ days	31 (41.33%)

The four CAT-T items patients rated highest (highest % of excellent ratings) were: showed care and concern (76.0%), paid attention to me (74.7%), checked to be sure I understood everything (73.3%), and spent the right amount of time with me (72.0%). The four CAT-T items patients rated the lowest (lowest % of excellent ratings) were: encouraged me to ask questions (61.3%), discussed next steps including any follow-up plans (62.7%), involved me in decisions as much as I want (64.0%), and showed interest in my ideas about my health (65.3%). Table 3.2 shows the CAT-T items, percentage of excellent scores, number of patients that responded with "excellent" for that item, mean score, and median score. The average score per CAT-T item (1-13) was 4.51. The median score was 5.

Table 3.2 CAT-T items, percentage of excellent, mean, and median scores

Communication Assessment Tool - Team Item	Patients who responded "excellent" (%)	Mean Score	Median Score
1. Greeted me in a way that made me feel comfortable	51 (68.0%)	4.57	5
2. Showed Interest in my ideas about my health	49 (65.3%)	4.45	5
3. Understood my main health concerns	52 (69.3%)	4.50	5

4. Paid attention to me	56 (74.7%)	4.59	5
5. Let me talk without interruptions	52 (69.3%)	4.49	5
6. Gave me as much information as I wanted	50 (66.7%)	4.48	5
7. Talked in terms I understood	53 (70.7%)	4.61	5
8. Checked to be sure I understood everything	55 (73.3%)	4.57	5
9. Encouraged me to ask questions	46 (61.3%)	4.4	5
10. Involved me in decisions as much as I wanted	48 (64.0%)	4.44	5
11. Discussed next steps, including any follow-up plans	47 (62.7%)	4.39	5
12. Showed Care and concern	57 (76.0%)	4.68	5
13. Spent the right amount of time with me	54 (72.0%)	4.52	5
Below question was study-generated and was not part of the CAT-T survey			
14. How well did your hospitalist(s) inform you of their role?	51 (68.0%)	4.41	5
Below question was part of the CAT-T but does not assess communication and was not included in the overall CAT-T communication score			
15. How would you rate the care provided by your hospitalist team?	50 (66.7%)	4.52	5

Tables 3.3 - 3.8 show the Kruskal-Wallis test results based on the CAT-T questions, excellent responses, and demographic and clinical data. Median CAT-T score is displayed along with p-values. No significant differences were found in CAT-T scores based on any demographic or clinical variable.

Table 3.3: Kruskal-Wallis: Age group and CAT-T score

Age Group	N	Median CAT-T score	P-value
24 or Younger	1	65.0	0.841
25 to 44	3	61.0	
45 to 64	20	63.0	
65 to 84	45	63.0	
<85	6	65.0	

Table 3.4: Kruskal-Wallis: Gender and CAT-T score

Sex	N	Median CAT-T score	P-value
Male	36	63.5	0.742
Female	39	63.0	

Table 3.5: Kruskal-Wallis: Ethnicity and CAT-T score

Ethnicity	N	Median CAT-T score	P-Value
American Indian/Alaskan	1	65.0	0.369
Black/African American	1	61.0	
Hispanic/Latino	2	65.0	
White/Caucasian	71	63.0	

Table 3.6: Kruskal-Wallis: Diagnosis and CAT-T score

Diagnosis	N	Median CAT-T score	P-Value
Medical	58	64.0	0.146
Surgical	17	61.0	

Table 3.7: Kruskal-Wallis: Relationship with hospitalist and CAT-T score

Previously Interacted with Hospitalists?	N	Median CAT-T score	P-Value
No	58	62.5	0.503
Yes, only once	10	65.0	
Yes, More than Once	7	63.0	

Table 3.8: Kruskal-Wallis: Years with PCP and CAT-T score

Years with PCP	N	Median CAT-T score	P-Value
1 Year or Less	6	65.0	0.620
2 -5 Years	15	65.0	
6-10 Years	15	61.0	
11-15 Years	15	61.0	
>16 Years	18	64.5	

In order to examine whether assigned nursing unit was associated with satisfaction, participants were grouped together by comparable unit characteristics. Subjects were grouped according to specialties (i.e., medical or surgical), similarities in room design (i.e., semi-private vs. private), or location in the same building or annex. A total of five groupings were developed to account for the various units throughout the hospital: cardiac/single room/same building (n = 17), general surgical and semi-private rooms (n = 23), orthopedic and surgical /all private rooms (n = 8), oncology and surgical / all private rooms (n = 22), and orthopedic and surgical /all semi-private rooms (n = 5). This was performed to analyze if there were any differences in satisfaction with communication based on nursing unit characteristics. Analysis using the Kruskal-Wallis test for assigned nursing unit and median CAT-T score did not reveal any statistically significant findings. This can be interpreted as patients' nursing unit location or room assignment did not affect the overall CAT-T score.

A multivariate regression analysis was also utilized to examine the contribution of the demographic (age, gender, ethnicity) and clinical (nursing unit, length of stay, diagnosis category, duration of relationship with PCP, number of hospitalists seen) variables to the CAT-T total score. The only significant predictor was diagnostic category. Individuals with surgical diagnoses (n = 17) reported less satisfaction with communication.

To test the first hypothesis, which was, patients who report more excellent communication experiences with the hospitalist team will be more satisfied with the quality of their medical care, the correlation between the overall communication score rating from the CAT-T and satisfaction with medical care was computed. The Pearson correlation of 0.863, with a $p < 0.001$, supports the hypothesis.

To test hypothesis two, which stated, patients without a PCP will report more interactions as excellent from their hospitalist(s) than those with a PCP, and hypothesis three, patients who interact with more than one hospitalist will rate more interactions less than excellent, Kruskal-Wallis analysis was utilized to test the median CAT-T scores for satisfaction per group (i.e., PCP vs. no PCP and number of hospitalists seen (1 vs. > 1). No significant differences in satisfaction with communication were found; thus hypotheses two and three were not supported (see tables 3.9 and 3.10).

Table 3.9: Kruskal-Wallis: PCP relationship and CAT-T score

PCP Relationship	N	Median CAT-T score	P-value
Yes	69	63.0	0.884
No	6	63.5	

Table 3.10: Kruskal-Wallis: Number of hospitalists interacted with and CAT-T score

Hospitalists Interacted with	N	Median CAT-T score	P-value
Group 1 (1)	44	63.0	0.429
Group 2 (1-3)	29	64.0	
Group 3 (3-6)	2	54.5	

The number of hospitalists patients interacted with was then further condensed to two groups, 1 hospitalist or greater than 1 hospitalist. This was done because of ambiguity within the rating system of the question design. The results did not show statistical significance ($p = 0.966$) (see table 3.11).

Table 3.11: Kruskal-Wallis: Condensed groupings of hospitalists interacted with and CAT-T score

Hospitalists interacted with	N	Median CAT-T score	P-value
Group 1 (1)	44	63.0	0.966
Group 2 (>1)	31	64.0	

Hypothesis four predicted a negative association (inverse relationship) between length of stay and satisfaction, i.e., a longer length of stay will be associated with fewer interactions rated as "excellent" by patients. A Kruskal-Wallis test was utilized to examine LOS and its effect on satisfaction. While results were in the expected direction, the obtained p-value was not significant at 0.067 (see table 3.12).

Table 3.12: Kruskal-Wallis: Satisfaction and lengths of stay

LOS Grouping	N	Median CAT-T score	P-Value
1 (1-3)	19	61	0.067
2 (4-6)	25	65	
3 (7+)	31	72	

Further statistical analysis was performed using a Non-Parametric Mann-Whitney U test, which revealed a statistically significant difference between total CAT-T score by LOS groups. Those patients staying the fewest days (Group 1 = 1 - 3 days) reported less satisfaction with communication (median = 61; mean = 53.84) than those who stayed 4 - 6 days (Group 2) (median = 65; mean = 61.76). In other words, patients that were at the hospital for fewer days were less satisfied with communication. No significant differences were found among the group with the longest LOS (Group 3 = >7 days) (median = 62; mean = 59.23) and Groups 1 and 2 (see tables 3.13 - 3.16).

Table 3.13: Mann-Whitney U Test: Lengths of stay [(1-3 days) vs. (4-6 days)] and CAT-T score

LOS Groupings	N	Median CAT-T score	P-Value
Group 1: LOS 1-3 days	19	61.0	0.0244
Group 2: LOS 4-6 days	25	65	

Table 3.14: Mann-Whitney U Test: Lengths of stay [(1-3 days) vs. (>7 days)] and CAT-T score

LOS Groupings	N	Median CAT-T score	P-Value
Group 1: LOS 1-3 days	19	61.0	0.238
Group 3: LOS >7 days	31	62.0	

Table 3.15: Mann-Whitney U Test: Lengths of stay [(4-6 days) vs. (>7 days)] and CAT-T score

LOS Groupings	N	Median CAT-T score	P-Value
Group 2: LOS 4-6 days	25	65	0.1713
Group 3: LOS >7 days	31	62	

Table 3.16: Summary mean and median: Lengths of stay and CAT-T score

LOS Groupings	N	Mean	Median
1: 1-3 days	19	53.84	61.0
2: 4-6 days	25	61.76	65.0
3: >7 days	31	59.23	62.0

There is a significant difference between total CAT-T score (items 1 – 13) between group 1 (1 - 3 days) and group 2 (4 - 6 days), but not between groups 1 and 3 or groups 2 and 3. This indicates that patients who were in the hospital for fewest days were less satisfied with communication than those who had slightly longer stays (4 - 6 days), but not those who had the longest length of stay (7 or more days).

Chapter Four

Discussion

Medicine is a moral community because it is at heart a moral enterprise and its members are bound together by a common moral purpose.
——— Edmund D. Pellegrino and David C. Thomasma

The association between patients' perceptions and ratings of excellent communication and excellent medical care was proven in this study. However, there were no statistically significant findings when the CAT-T scores were examined in relation to whether patients had an established relationship with a PCP. Also, interaction with more than one hospitalist did not have a significant association with CAT-T scores. Analysis suggests that satisfaction with communication did not vary in relation to age, gender, or ethnicity of patients.

Hypothesis 1 was supported. It was stated, patients who report more excellent communication experiences with the hospitalist team will be more satisfied with the quality of their medical care. The percentage of excellent responses from the CAT-T (items 1-13) was 68.7% and 66.7% for the question, "How would you rate the care provided by your hospitalist team?" Pearson correlation = 0.863, $p < 0.001$. This means that as satisfaction with communication increases, satisfaction with medical care increases.

Hypothesis 2 which stated, patients without a PCP will report more interactions as excellent from their hospitalist(s) than those with a PCP, was not supported.

There were only 6 patients without a PCP. The median overall CAT-T score for these patients was 63.5. The median overall CAT-T score for patients with PCPs was 63. The median CAT-T rating for both patient categories (i.e., those with a PCP and those without a PCP) was 5. There was no significant difference between the two groups, indicating the patients were equally satisfied whether or not they had a PCP.

Hypothesis 3 stated, patients who interact with more than one hospitalist will rate more interactions less than excellent. Forty-four (44) patients communicated with only one hospitalist and 31 patients communicated with more than 1 hospitalist. The analysis revealed there was no significant difference between the total CAT-T scores analyzed and the number of hospitalists with whom the patient communicated. This hypothesis was not supported.

Hypotheses 2 and 3 proposed that patient satisfaction with communication from hospitalists would be affected by established PCP relationships and the number of hospitalists seen; however, these hypotheses were not supported. This may have been because hospitalist medicine has been in existence at the study site from as early as 1998. The challenges and roadblocks first observed at inception have been minimized in this facility (study site).

The hospitalist group that participated in this study works to facilitate patient connections during hospitalization. Hospitalists are assigned to a particular unit and follow patients throughout their stay. There is consistency in care unless a hand-off between hospitalists occurs. Care is also handed off for weekend and holiday coverage. The study survey was not administered during these times.

The study hospitalists have pre-established protocols that are followed when communicating with PCPs. When interviewed, many patients were aware and had been informed that the hospitalists were communicating with their PCP. For example, one patient stated that the hospitalist called the PCP to clarify a medication dose. The hospitalists work hard to maintain good communication with their patients. Like all physicians, they are very aware of the financial implications for poor patient ratings regarding the quality of care.

Hospitalists are obligated to follow hospital mandates and also benefit from quality improvement initiatives. Communication scores from patients are routinely posted in staff areas of the hospital for quality improvement purposes. Communication is at the forefront of quality improvement strategies at the study site.

Hypothesis 4 examined individual subject length of stay and its effect on satisfaction with hospitalist communication. The hypothesis predicted a negative association (inverse relationship) between length of stay and satisfaction; i.e., a longer length of stay will be associated with fewer interactions rated as "excellent" by patients. This hypothesis was not supported. The overall excellent rating for satisfaction with communication was 68.7%. The individuals who were hospitalized for only 1- 3 days had a lower satisfaction with communication score than patients that were hospitalized longer. Utilizing a non-Parametric Mann-Whitney U test, a statistically significant difference of satisfaction with communication between groups 1 (1-3 days) and group 2 (4 - 6 days) in median CAT-T score ($p = 0.0244$) was found. There was no statistically significant difference in satisfaction with communication with shorter stays compared to a longer stay between groups 1 (1 - 3 days) and group 3 (7+ days) ($p = 0.238$), and group 2 (4 - 6 days) and group 3 (7+ days) ($p = 0.1713$).

Those who were hospitalized for 1 - 3 days were significantly less satisfied than those hospitalized for 4 - 6 days ($p = 0.0244$). This result could be because patients who have a longer LOS have more time to develop a rapport with hospitalists. The acuity of illness upon hospital presentation may also affect patients' ability to interpret and participate in communication with hospitalists. Acuity can impact LOS, which in turn impacts satisfaction. For example, higher acuity routinely demands a longer length of stay. As the hospital stay extends, patients have had time to become familiar with their hospitalists and communication with them may be perceived positively. The initial fear, worry, and anxiety at the time of hospitalization, coupled with the fact that their PCP is not managing hospital care and the short period of time to develop a relationship with their hospitalist, may cause patients hospitalized from 1 - 3 days to rate communication lower than those patients who stay 4 - 6 days. Future research should examine lengths of stay as it relates to patient satisfaction with communication.

The findings from this study are consistent with published research on patient satisfaction with hospitalist communication indicating that patients tend to be satisfied with hospitalist communication as previously discussed. There were no significant differences in overall CAT-T score by demographic characteristics such as age, ethnicity, and gender. This study expands the prior literature by identifying associations between satisfaction with communication and diagnostic category and LOS, which to the best of my knowledge has not been documented in the literature.

Limitations

The study did have several limitations that must be considered. Only one facility and one hospitalist group were used for the study. There are other hospitalists rendering care at the study site that were not included. The group selected had the highest patient volume and provided coverage on all adult medical and surgical units at the facility. By only having one practice group represented, variations in physician practice were not considered. Although it was not a goal of the present study to compare different hospitalist groups, future research should examine differences between groups.

The study was conducted during daytime hours (9am – 3pm) from Monday through Friday. Most discharges are planned for daytime hours; however, last-minute evening discharges could have been missed. In addition, the study survey was not given over the weekend. This was primarily in consideration of the additional patient load the covering hospitalists typically carry over the weekend. The weekend hospitalists may not have been familiar with all patients or have had the time to collaborate with the PI regarding discharges and inclusion/exclusion criteria. Omitting these patients may have influenced the study results as there are additional challenges (i.e., limited ancillary services) in managing and preparing discharges in the evening and weekend hours, which could affect patient satisfaction and perceptions of communication. Future research should be conducted to include evenings and weekends to examine this specific population of patients as it relates to satisfaction with communication.

Another limitation was the day of the week in which surveys were administered. The study survey was administered until the enrollment goal of 75 was achieved. Enrollment goal was met after 7 days. Daily enrollment numbers were: Thursday = 9,

Friday = 20, Monday = 2, Tuesday = 12, Wednesday = 10, Thursday = 6, and Friday = 16. There was a drop in referrals on Monday; therefore enrollment was considerably lower on this day. It is possible that the hospitalists were not familiar with patients that were admitted over the weekend and could not assess inclusion/exclusion criteria to refer patients to the PI. Results could have been affected by physicians not being acquainted with patient conditions, plans, and discharges thereby affecting referrals to the study. Friday had the highest number of referrals. Future studies may want to consider this inconsistency when planning recruitment strategies.

The survey was administered face-to-face. Although clinical staff did not participate in the administration of the survey, subjects may have been reluctant to be honest in their evaluation for fear it may have an effect on their ongoing care. In an effort to minimize this bias, participants were advised at the outset of the interview that the study was confidential and the results would not affect their care.

Because of the error in coding the number of hospitalists that patients interacted with during their hospital stay, we were only able to examine whether satisfaction varies in patients with one versus more than one hospitalist. Future research should examine whether the number of hospitalists is perhaps linearly associated with satisfaction.

Patients were asked whether they had a PCP. If the patient responded yes, the number of years he/she had been involved with the PCP was documented. The study did not ask patients if they were or were not satisfied with the established relationship, nor did it allow for further comment by the patient specifically on the relationship with the PCP. Satisfaction with the present PCP-patient relationship was not addressed. Future research should be conducted to further study patients' satisfaction with their established PCP relationship and determine if there is any correlation with hospitalist satisfaction.

The small size of some of the demographic categories was also a limitation. Age group less than or equal to 24 years reported only 1 subject and age group 25 - 44 had 3 subjects. Only 6 patients did not have a PCP. Statistical power could have been affected by these low numbers. Also, the study population was homogenous with regards to race, 71 patients were Caucasian. Future studies may want to consider larger enrollment numbers of these patient categories.

Chapter Five

Conclusion

> Once I knew only darkness and stillness... my life was without past or future... but a little word from the fingers of another fell into my hand that clutched at emptiness, and my heart leaped to the rapture of living.
> ——— Helen Keller

The complex care delivered in tertiary settings today demands the attention of devoted health care practitioners. Hospitalists are part of this group of specialized individuals. Their hospital-based practice requires effective patient communication. An assessment of the factors associated with patient satisfaction with hospitalists' communication is important insofar as patient satisfaction scores are now related to physician and hospital reimbursement. Therefore, identifying areas for improvement is vital.

The relationship between hospitalists and patients is initiated and must be cultivated in the stressful environment of the hospital. These patients are not provided the same quiet and controlled outpatient office setting to which most patients are accustomed. Patients managed by hospitalists are often first seen and examined in the ER, where chaos can reign. For the majority of these patients, this is their first encounter with a hospitalist; in this location, it can be difficult to develop a rapport and establish a therapeutic relationship.

Throughout patients' hospital stays, hospitalists will manage their medical care. Hospitalists will determine which diagnostic tests are performed, which medications patients will take during their hospital stay, and which medications patients will be prescribed upon discharge. The communication among hospitalists, patients, and PCPs needs to be complete and concise. If communication becomes vague and uncertain, an outcome as serious as death can occur.

There is no disputing that hospitalist medicine changes the dynamic relationship between PCPs and patients when hospitalization is necessary. Patients may feel a sense of loss at the sudden cessation of their previously established relationship with their PCPs. Open, effective communication between PCPs and patients regarding the use of hospitalists, in the event of hospitalization, should occur in a proactive manner. PCPs need to be accessible to hospitalists rendering care to their patients.

The interruption of the PCP-patient relationship can be a disadvantage to hospitalist medicine. This therapeutic relationship has been nurtured for extended periods of time, in some cases, for generations; and at the time of a hospital admission, a crisis point, it is abruptly discontinued. The roles of PCPs during hospitalization need to be explained to the patient (i.e., PCPs are not physically on site nor are they managing patient care, but can act as consultants). Patients may be disappointed and feel abandoned once at the hospital. The abrupt discontinuation of the PCP-patient relationship can compromise patient care. Disclosure and acknowledgement of pertinent past medical history and health-related information, developed over the course of the PCP-patient relationship, may be lost or misconstrued. Patients need to understand and believe that the lines of communication are open, and that PCPs are being informed of their hospital

course and consulted as needed. However, this study did not demonstrate any differences, with regards to overall excellent responses on the CAT-T, between patients who had a PCP relationship and patients who did not.

Hospitalists must clearly explain their role and purpose to patients. It is important to emphasize that patients will return to the care of their PCPs at the time of discharge. Sixty-eight percent (68.0%) of subjects in this study responded "excellent" to "How well did your hospitalist inform you of their role?" This result demonstrates that not all hospitalists are effectively communicating their role to patients; there is room for improvement. Ideally, 100% of patients under the care of hospitalists should understand the role of the hospitalist who is managing their care. An appropriate hand-off in care from hospitalization to discharge/outpatient management is critical to avoiding errors and miscommunication.

Hospitalist medicine routinely involves a team approach, and patients may see multiple hospitalists who provide around-the-clock care during the hospital stay. Without clear, comprehensive communication between patients and hospitalists, this team approach can interrupt and obstruct the plan of care. As demonstrated by results in this study, there was no difference in overall CAT-T responses if patients saw one or more than one hospitalist. In this study, 41.33% of patients interacted with more than one hospitalist. All hospitalists should be striving to effectively communicate with their patients; and patients need to perceive and believe that the communication between them and their hospitalist is effective.

There are many advantages and disadvantages to the hospitalist medicine approach to patient care. There is no disputing that due to their constant presence in the

hospital, hospitalists become familiar with the acute care setting. They are trained to manage patients in this environment. Hospitalists gain expertise in hospital policies and procedures. They are available around-the-clock. This facilitates expedition in receipt and interpretation of diagnostic studies and triaging of patients. Communication of such results to patients is an important part of managing their care in hospitals.

A dialogue and patient rapport needs to be established early in the hospitalization. As results in this study demonstrate, shorter lengths of stay resulted in fewer "excellent" CAT-T item responses reported by patients. As lengths of stay were extended, patients' perception of excellent interactions increased. The first interactions with patients are important and can affect patients' opinions of hospitalists' communication. In this study, shorter lengths of stay were associated with fewer "excellent" responses to the CAT-T items.

Communication with patients needs to be at the forefront of care and incorporated into practice models. Proven in this study is the association between patient perceptions of excellent communication and satisfaction with medical care rendered. Hospitalists will continue to be an important part of our health care delivery system and must strive to provide humanistic care. Hospitalists need to continue to work on their communication skills to provide the best outcomes for patients. Patients' perceptions of the communication style from hospitalists can greatly affect their satisfaction with the hospitalist team and the care provided. No longer is it a personal preference to provide patients with good communication. Rather, communication is a priority for hospitals and impacts their "bottom line." The need to meet national standards for quality care, and therefore reimbursement, is paramount.

Communication assessment and evaluation will remain at the forefront of hospitals' agendas as communication and satisfaction remain measurable outcomes for residency education programs, the physician certifying board, national regulatory agencies, and consumer advocacy groups. The ACGME and the ABMS identify interpersonal and communication skills as a core competency for all physicians. Residency programs evaluate physician competency in communication prior to completion of the program. The study site is a teaching hospital and residents in practice at the site must meet this standard. Using a communication assessment tool can assist in identifying areas of improvement, which can be targeted in interventions to improve communication.

This research evaluated patients' perception of communication from hospitalists. The Medical Humanities program at Drew University emphasizes the evolution of the doctor-patient relationship and recognizes ethically charged health care related phenomena. Hospitalists challenge this relationship and alter the historic doctor-patient relationship, but they can be valuable health care team members if effective communication remains a priority.

Further Research

Further research should continue to focus on patient satisfaction with the hospitalist model of care. Due to the economic constraints on health care systems and hospitals in general, it is anticipated that hospitalists will remain an important part of acute care delivery. In addition to fiscal studies for documentation of savings and economic feasibility, patient satisfaction must be a priority. Routine assessment of factors

associated with hospitalists' communication skills should be performed and improvement tactics instituted to improve communication experiences for patients.

A study examining satisfaction by day of discharge (i.e., weekday versus weekend) should be conducted. There are challenges with weekend discharges. There routinely are fewer ancillary weekend staff members (i.e., social workers or case managers) to assist with discharge needs. Physician coverage on the weekends rotates more frequently than weekday coverage, which may alter communication, thereby affecting satisfaction.

Also, a study further investigating satisfaction with the pre-established patient-PCP relationship may be warranted. Research should look at whether different aspects of the patient-PCP relationship (i.e., satisfaction with the PCP, closeness of the relationship, intention to maintain the relationship) are differentially associated with satisfaction with communication from hospitalists.

Additional, larger studies evaluating lengths of stay and communication satisfaction should be conducted. This study found a statistically significant relationship between shorter lengths of stay and less than excellent CAT-T item responses. Future studies should attempt to replicate the finding that LOS is associated with satisfaction with communication in larger samples, with different hospitalist groups. Strategies to enhance communication early on in the hospitalization may be warranted to improve patients' perceptions of the interactions.

Hospitalists are delivering and managing care of hospitalized patients; the quality of the care rendered will continue to be assessed by patients and health care facilities. The use of hospitalists has continued to increase along with the volume of patients under their care. Emphasis is placed on the quality of care as it related to patient satisfaction and

subsequent insurance reimbursement. Communication, as interpreted by patients, will continue to be an important quality measure.

Appendix A

Guidelines for Interaction in Hospitalist Models
Communication between the Receiving Inpatient Care Management Physicians and the Referring Primary Care Physician[136]

Family physicians are participating on *both sides* of the new models of health care delivery, which utilize a dedicated inpatient physician (or hospitalist) to manage the inpatient care of general adult medicine patients referred by primary care physicians in the community. The AAFP believes that family physicians are well trained and highly qualified to serve in these roles, and that participation in such arrangements should be voluntary for both the referring physician and the patient involved.

Because continuity of care has been a hallmark of the specialty of family practice, the AAFP is especially concerned about safeguarding continuity in these new models through adequate communication. The following guidelines are intended to support quality care to patients and their families, and to clarify expectations for communication between physicians participating in such systems.

1. The overarching objective for all should be the best possible care for the patient.
2. At the request of the family physician (or other primary care physician), the inpatient care physician (who may also be a family physician) should admit and coordinate the care of all patients admitted to the hospital regardless of the admitting diagnosis or type of insurance coverage.
3. If patients present to the emergency department (ED) and the ED physician assesses them, the ED physician should then contact the patient's family physician to determine if admission is necessary or if close follow up or outpatient work up is more appropriate.
4. If admission is necessary, the family physician should communicate information on pre-hospital treatment, work up, co-morbidities, and ongoing specialty consultations, along with family and social concerns, advance directives, etc., to the inpatient care physician who is assuming management of the patient's care.
5. The inpatient care physician will assess the patient at admission and determine the best course of treatment. This may include treat and release, admit for general medical management, or admit for medical or surgical subspecialty care, while providing general medical oversight.
6. During the period of hospitalization, decisions regarding care, consultation, admission, transfer, and discharge should be the sole responsibility of the inpatient care physician in consultation with the patient and, as appropriate, the patient's family physician and/or family members.
7. The inpatient care physician should be readily available to discuss the patient's medical problems and hospital course with the family and should provide timely updates to the family physician designated by the patient. Communication with the

[136] American Academy of Family Physicians, http://www.aafp.org/practice-management/administration/hospitalists.html (accessed November 9, 2014).

family is extremely important at the time of any changes in the patient's status, complications or new diagnosis (e.g., cancer).

8. The inpatient care physician should communicate the treatment plan and follow-up recommendations to the patient's family physician or the covering physician on the day of discharge.
9. When family physicians refer their hospital patients to the care of an inpatient physician, ongoing communication should be maintained with the patients and their families throughout the hospitalization. Family physicians should also provide written communication to the inpatient care physician after the first post-hospital visit at the office where there may be an educational benefit.
10. Health care systems which utilize inpatient care management models should seek to constantly monitor and improve their processes through the use of ongoing surveys for patient and physician satisfaction with the system. Data on health care outcomes is essential to the ultimate evaluation of these models.

Hospitalist Systems of Inpatient Care Management

As health care systems experiment with models of inpatient care management (hospitalist systems), the AAFP supports and encourages the following principles:

- The opportunity to participate as a hospitalist in such systems must be open to all interested physicians whose education, training, and current competence qualify them to serve effectively in this role.
- The decision of who should care for a family physician's hospitalized patients should be made by the patient and his or her family physician, in the interest of what is best for patient care (i.e., participation in hospitalist models should be voluntary).
- In the interest of preserving continuity, patient advocacy and health care decision-making which is in concert with the patient's values, generalists should be used for inpatient general medical management. Consultation with an intensivist, medical, or surgical subspecialist does not preclude the need for the continuing, comprehensive, and personal care provided by a generalist physician.
- In the event that family physicians elect to refer their patients for inpatient care management, open communication should be maintained with those patients and their families throughout the hospitalization.
- While family physicians may elect to refer patients for inpatient care management, they should strongly consider the mid- and long-range implications for their practices before they relinquish hospital privileges. Such implications may include:
    - difficulty being credentialed and/or reimbursed by managed care companies for services/procedures in the ambulatory setting if one does not have hospital privileges for those same services/procedures, and/or
    - being unable to successfully reapply for hospital privileges at future points of career transition, without the necessity of seeking substantial additional education and retraining.

Appendix B

Oath of Hippocrates, Circa 400 B.C.[137]

I SWEAR by Apollo the physician and Æsculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment,

I will keep this Oath and this stipulation — to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction,

I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.

I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art.

I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad,

I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.

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[137] *Oath of Hippocrates*, Harvard Classics 38 (Boston: P.F. Collier and Son, 1910). http://www.cirp.org/library/ethics/hippocrates/ (accessed April 11, 2015).

Appendix C

Hippocratic Oath (Modern version)[138]

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

[138] Louis Lasagna, “Hippocratic Oath,” (Massachusetts: Tufts University, 1964).

Appendix D

Joint Commission – RC.02.04.01 Discharge Information

Program: Hospital

Chapter: Record of Care, Treatment, and Services

RC.02.04.01: The hospital documents the patient's discharge information.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.58(b)(2) §483.12(a)(3) §483.12(a)(3)(i) §483.12(a)(3)(ii)	M			C	ESP-1

2 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The resident's discharge information includes the following:
- The reason for transfer, discharge, or referral
- Treatment provided, diet, medication orders, and orders for the resident's immediate care
- Referrals provided to the resident, the referring licensed independent practitioner's name, and the name of the licensed independent practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring licensed independent practitioner
- Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals
- Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
- Nursing information that is useful in the resident's care
- Any advance directives
- Instructions given to the resident before discharge

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.58(b)(2) §483.12(a)(3) §483.12(a)(3)(i) §483.12(a)(3)(ii)	M			C	ESP-1

3 In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:
- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient's condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.
Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- FSA Direct Impact EPs	§482.24(c)(4)(vii) §482.61(e) §482.61(e) §482.61(e)	M	⚠		C	

Appendix E Form T
Original CAT-T

Communication Assessment Tool

Communication with patients is a very important part of quality medical care. We would like to know how you feel about the way your medical team communicated with you. **Your answers are completely confidential, so please be as open and honest as you can**. Your participation is completely voluntary and will not affect your medical treatment in any way. Please rate the medical team's communication with you. Circle your answer for each item below. Thank you very much.

The Medical Team…	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
1. Greeted me in a way that made me feel comfortable	1	2	3	4	5
2. Treated me with respect***	1	2	3	4	5
3. Showed interest in my ideas about my health	1	2	3	4	5
4. Understood my main health concerns	1	2	3	4	5
5. Paid attention to me (looked at me, listened carefully)	1	2	3	4	5
6. Let me talk without interruptions	1	2	3	4	5
7. Gave me as much information as I wanted	1	2	3	4	5
8. Talked in terms I could understand	1	2	3	4	5
9. Checked to be sure I understood everything	1	2	3	4	5
10. Encouraged me to ask questions	1	2	3	4	5
11. Involved me in decisions as much as I wanted	1	2	3	4	5
12. Discussed next steps, including any follow-up plans	1	2	3	4	5
13. Showed care and concern	1	2	3	4	5
14. Spent the right amount of time with me	1	2	3	4	5
The Front Desk Staff…* **	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
15. Treated me with respect***	1	2	3	4	5

~ continues on other side ~

***These questions were not asked for this study.

Your Care	Poor	Fair	Good	Very Good	Excellent
16. How would you rate the care provided by your medical team?	1	2	3	4	5

Comments:

****

This set of questions <u>about the patient</u> is for statistical purposes. Your own responses are completely confidential. Please mark one answer for each question.

1. How old are you?
   - ☐1 24 or younger
   - ☐2 25-44
   - ☐3 45-64
   - ☐4 65-84
   - ☐5 85 or older

2. Are you male or female?
   - ☐1 Male
   - ☐2 Female

3. Have you seen this doctor before?
   - ☐1 No
   - ☐2 Yes, but only once
   - ☐3 Yes, more than once

4. How would you describe your race or ethnicity?
   - ☐1 American Indian or Alaska Native
   - ☐2 Asian or Asian-American
   - ☐3 Black or African-American
   - ☐4 Hispanic or Latino
   - ☐5 Native Hawaiian or Pacific Islander
   - ☐6 White or Caucasian
   - ☐7 Other _____

5. Were you the patient today?
   - ☐1 Yes
   - ☐2 No, I was with the patient today

Thank you very much.

Appendix F

HCAHPS Survey

SURVEY INSTRUCTIONS

- You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- Answer all the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  ☐ Yes
  ☑ No ➔ ***If No, Go to Question 1***

You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.
Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

2. During this hospital stay, how often did nurses listen carefully to you?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

6. During this hospital stay, how often did doctors listen carefully to you?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

9. During this hospital stay, how often was the area around your room quiet at night?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 12**

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

12. During this hospital stay, did you need medicine for pain?

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 15**

13. During this hospital stay, how often was your pain well controlled?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

15. During this hospital stay, were you given any medicine that you had not taken before?

[1]☐ Yes
[2]☐ No ➔ **If No, Go to Question 18**

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

[1]☐ Never
[2]☐ Sometimes
[3]☐ Usually
[4]☐ Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

[1]☐ Never
[2]☐ Sometimes
[3]☐ Usually
[4]☐ Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

[1]☐ Own home
[2]☐ Someone else's home
[3]☐ Another health facility ➔ **If Another, Go to Question 21**

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

[1]☐ Yes
[2]☐ No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

[1]☐ Yes
[2]☐ No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

[0]☐ 0 Worst hospital possible
[1]☐ 1
[2]☐ 2
[3]☐ 3
[4]☐ 4
[5]☐ 5
[6]☐ 6
[7]☐ 7
[8]☐ 8
[9]☐ 9
[10]☐ 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?

[1] ☐ Definitely no
[2] ☐ Probably no
[3] ☐ Probably yes
[4] ☐ Definitely yes

UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

[1] ☐ Strongly disagree
[2] ☐ Disagree
[3] ☐ Agree
[4] ☐ Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

[1] ☐ Strongly disagree
[2] ☐ Disagree
[3] ☐ Agree
[4] ☐ Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.

[1] ☐ Strongly disagree
[2] ☐ Disagree
[3] ☐ Agree
[4] ☐ Strongly agree
[5] ☐ I was not given any medication when I left the hospital

ABOUT YOU

There are only a few remaining items left.

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?

[1] ☐ Yes
[2] ☐ No

27. In general, how would you rate your overall health?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

28. In general, how would you rate your overall <u>mental or emotional health</u>?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

29. What is the highest grade or level of school that you have <u>completed</u>?

[1] ☐ 8th grade or less
[2] ☐ Some high school, but did not graduate
[3] ☐ High school graduate or GED
[4] ☐ Some college or 2-year degree
[5] ☐ 4-year college graduate
[6] ☐ More than 4-year college degree

30. Are you of Spanish, Hispanic or Latino origin or descent?

- [1] ☐ No, not Spanish/Hispanic/Latino
- [2] ☐ Yes, Puerto Rican
- [3] ☐ Yes, Mexican, Mexican American, Chicano
- [4] ☐ Yes, Cuban
- [5] ☐ Yes, other Spanish/Hispanic/Latino

31. What is your race? Please choose one or more.

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or other Pacific Islander
- [5] ☐ American Indian or Alaska Native

32. What language do you <u>mainly</u> speak at home?

- [1] ☐ English
- [2] ☐ Spanish
- [3] ☐ Chinese
- [4] ☐ Russian
- [5] ☐ Vietnamese
- [6] ☐ Portuguese
- [9] ☐ Some other language (please print): _____

THANK YOU

Please return the completed survey in the postage-paid envelope.

[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

Appendix G
National Patient Safety Goals

2015 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
NPSG.01.03.01	Make sure that the correct patient gets the correct blood when they get a blood transfusion.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
NPSG.07.03.01	Use proven guidelines to prevent infections that are difficult to treat.
NPSG.07.04.01	Use proven guidelines to prevent infection of the blood from central lines.
NPSG.07.05.01	Use proven guidelines to prevent infection after surgery.
NPSG.07.06.01	Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.
Identify patient safety risks	
NPSG.15.01.01	Find out which patients are most likely to try to commit suicide.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission
Accreditation
Hospital

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

Appendix H
Additional Study Questions

	Poor	Fair	Good	Very Good	Excellent
How well did your hospitalist(s) inform you of their role?	1	2	3	4	5

Do you have a Primary Care Physician? ☐ [1] Yes If yes, how long have you seen this PCP? _____ years
☐ [2] No

In total, how many hospitalists have you interacted with during this admission?

☐[1] 1
☐[2] 1-3
☐[3] 3-6
☐[4] 7 or more

How long have you been in the hospital? _____days

Diagnosis:

Appendix I
Hospitalist Participation Agreement

PATIENT SATISFACTION
WITH
COMMUNICATION FROM HOSPITALISTS

IRB Approval # 669230-1

By signing below, I am allowing Patricia Baxter, RN, MSN, Principal Investigator, to contact my patients for participation in this study.

_____	_____	_____
Name	Signature	Date

Appendix J
IRB Approval and Application

Atlantic Health System

Institutional Review Board
475 South Street
Morristown, NJ 07960
Phone: (973) 660-3128
Fax: (973) 292-7923

Morristown Medical Center
Overlook Medical Center
Newton Medical Center
Chilton Medical Center
Goryeb Children's Hospital

TO: Patricia Baxter, MSN

PROJECT TITLE: [669230-1] Satisfaction with Communication from Hospitalists

REFERENCE #:

SUBMISSION TYPE: New Project

ACTION: APPROVED

REVIEW DATE: 11/25/14

APPROVAL DATE: 11/25/14

EXPIRATION DATE: 11/24/15

REVIEW TYPE: Expedited

NUMBER OF APPROVED CONSENT FORMS: *[0]*

REVIEW CATEGORY: # *[7*

HIPAA:	☐ Obtain Authorization	☒ Waiver of HIPAA Authorization
CONSENT:	☐ Obtain Consent	☐ Waiver of Consent
	☐ Alteration of Consent	☒ Waiver of Documentation of Consent

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The submission reviewed for above-referenced protocol has received approval based on applicable federal regulations.

No investigator involved in the above referenced protocol participated in the vote to approve the study.

The following items were reviewed with this submission:

- Abstract/Summary - Description Letter (UPDATED: 11/8/2014)
- Application Form - Form 14 Patient Satisfaction Baxter (UPDATED: 11/17/2014)
- Application Form - Expedited Review App (UPDATED: 11/8/2014)
- CV/Resume - Patricia Baxter (UPDATED: 11/8/2014)
- HIPAA Waiver - IRB Form 7 (UPDATED: 11/12/2014)

- Letter - Nursing Research Letter of Approval (UPDATED: 11/8/2014)
- Protocol - Study Protocol (UPDATED: 11/8/2014)
- Questionnaire/Survey - Survey AND Physician Signature (UPDATED: 11/8/2014)

The following items were approved with this submission:

- Abstract/Summary - Description Letter
- HIPAA Waiver - IRB Form 7 (Waiver of Documentation of Consent)
- Protocol - Study Protocol
- Questionnaire/Survey - Survey AND Physician Signature

Report all events that are unanticipated problems, unanticipated problems, which are also adverse events, deaths occurring in subjects enrolled at an AHS facility, and deviations from the approved protocol that would place the subject at greater risk than anticipated, to the AHS IRB in writing immediately.

The Food and Drug Administration Amendment Act of 2007 requires that Phase II-IV trials of drugs and biologics and trials of devices be registered in ClinicalTrials.gov. The responsibility of registering these trials falls on the sponsor of the trials and/or the Principal Investigator. If you are conducting an "Investigator-initiated" study that fits the criteria above, you must register. If you are conducting a sponsored trial fitting the criteria, you must ensure that the sponsor registers.

Modifications to the study must be submitted in writing and approved by the AHS IRB prior to implementation of the changes.

Investigators are required (by Federal Regulations) to submit reports on the status and/or results of clinical studies approved by the AHS IRB. For the above-referenced study, status/result reports will be due on the basis indicated above and/or within 30 days of the termination of the investigation. It is the Principal Investigator's responsibility to secure continuing approval or notify the AHS IRB of termination of the study.

No subjects may be enrolled into this study after the above expiration date unless a continuation report is submitted and approved by the AHS IRB.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Atlantic Health System IRB's records.

Atlantic Health System

INSTITUTIONAL REVIEW BOARD
Request for Expedited Review (IRB Form-14)

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1. PROJECT			
Title: Patient Satisfaction with Communication from Hospitalists			
Sponsor: N/A		Sponsor's Protocol Number/Name: N/A	
2. PRINCIPAL INVESTIGATOR (PI)			
Name: Patricia Baxter		Degree(s): RN, MSN	
Department: Nursing		Title: Nursing Coordinator	
Mailing Address: xxxxxxxxx			
City: xxxxxxxxxx	State: NJ		Zip: 07xxx
Office Phone #: xxx-xxx-xxxx		Mobile Phone #: xxx-xxx-xxxx	
Email:		Fax: xxx-xxx-xxxx	
Is the PI an AHS employee or does s/he have privileges as AHS?	☒ Yes	☐ No	**Attach AHS IRB Form - #28 Unaffiliated Investigator Agreement**
Is the PI employed by AHS?	☒ Yes	☐ No	
2A. STUDY CONTACT *Individual to contact in addition to the PI to address any study related questions (e.g. clinical research coordinator).*			
Name: Patricia Baxter			
Email:		Phone:	

3. KEY PERSONNEL INFORMATION
Personnel involved in the study (e.g. substitute PI, sub-investigators, CRCs). Co-PIs are not permissible. Attach a separate sheet if necessary. Complete IRB Form #27 –Investigator Facesheet for each sub-investigator and CRC.

Name	**Role on the study**	**Contact with subjects or access to Protected Health Information (PHI)?**		**Involved in the consent process?**		**Will this person be involved in the recruitment of subjects?**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
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		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐

Educational requirements (initial and continuing) must be satisfied PRIOR to submitting the application for IRB review

Have all investigators and key personnel completed CITI training?	☒ Yes	☐ No	**Do not submit until training is complete**

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4. LOCATION OF THE RESEARCH
Check all that apply

☐ Chilton Medical Center	☐ Goryeb Children's Hospital	☒ Morristown Medical Center
☐ Newton Medical Center	☐ Overlook Medical Center	☐ Other:

4a. INSTITUTIONAL LOCATION OF THE RESEARCH
Provide the dept. (e.g. ICU, Cath Lab), contact name, and phone number for each dept. that will be involved in the study. Attach a separate sheet if necessary.

Dept. Name	Individual Contacted	Phone Number

5. PROJECT SUMMARY
Provide a brief overview of the proposed project in lay terminology in the space below.

Purpose of the study: The purpose of the study is to assess patient satisfaction with communication from hospitalists.

Description of procedures: A survey will be given to patients under the care of hospitalists prior to discharge.

Description of key subject enrollment criteria: Inpatients under the care of a hospitalist.

Description of potential benefits: To establish a baseline in the communication skills of hospitalists as interpreted by their patients during their admission.

Will the study involve the use of questionnaires, surveys, or scales?	☐ No	☒ Yes ➔ **Provide a copy**

6. RESEARCH METHODS & ACTIVITIES
Identify all interventions and interactions that are to be performed solely for the study

☐ Audio, video, digital, or image recordings	☐ Biological sampling (other than blood)	☐ Blood drawing
☐ Data, not publicly available	☐ Data, publicly available	☐ Deception
☐ Diet, exercise, or sleep modifications	☐ Focus groups	☐ Internet or e-mail data collection
☐ Non-invasive medical procedures (e.g. EKG, Doppler)	☐ Observation of participants (including field notes)	☐ Record review (which may include PHI)
☐ Specimen research	☒ Surveys, questionnaires, or interviews (one-on-one)	☐ Surveys, questionnaires, or interviews (group)
☐ Other Specify:		

6a. DRUGS/BIOLOGICS

☐ FDA-regulated Drug/Biologic IND not required ➔	**Explain why IND is not required:**

6b. DEVICES

☐ FDA regulated Device IDE not required ➔	**Explain why IDE is not required:**

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7. CATEGORIES FOR EXPEDITED REVIEW
Check the box next to the category that describes the project. If none of the categories apply in their entirety, complete an application for standard submission.

☐ **(1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met.** (a) Research on drugs for which an investigational new drug application) is not required (b) Research on medical devices for which (i) an investigational device exemption application is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.
Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for Expedited Review. If randomization is involved in the study, the study is not eligible for Expedited Review.

☐ **(2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:** (a) from healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ **(3) Prospective collection of biological specimens for research purposes by noninvasive means. Examples** (a) hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra-and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

☐ **(4) Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing.** ***Studies intended to evaluate the safety and effectiveness of a medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.*** Examples: (a) physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, Doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

☐ **(5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).**

☐ **(6) Collection of data from voice, video, digital, or image recordings made for research purposes.**

☒ **(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.**

Atlantic Health System

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8. SUBJECT POPULATION
Indicate the subject population that will be involved in the study. Check all that apply.

☒ Adults	☐ Pregnant women or fetuses
☐ Children (< 18 years) → ***Complete IRB Form #11 – Pediatric Risk Assessment***	☐ Neonates (uncertain viability/non-viable)
☐ Adults with decisional impairment STOP ***Discontinue completion of this form and submit IRB Form #1 – Application for Initial Review.***	☐ Prisoners
☐ Non-English speaking → ***Attach certified translated consent forms***	☐ AHS Employees or students
☒ Hospital In-patients	☐ Out-patients
Number of subjects to be enrolled at AHS: 75	Total number of subjects at all sites: 75
Exclusion criteria: Patients with mental impairment (ie: dementia) will be excluded.	

9. PARTICIPANT IDENTIFICATION, RECRUITMENT, & SELECTION

Describe how potential participants will be identified (e.g., advertising, individuals known to investigator(s), record review): Daily inpatient roster will be reviewed with the hospitalist team.

Explain how investigator(s) will gain access to this population, as applicable: Select hospitalists agreed to allow me access to their patients.

Describe the process that will be used to determine participant eligibility: Patients planned to be discharged within 48 hours will be approached to complete the survery. Input from the hospitalists and care managers regarding anticipated discharge date is expected.

Describe the recruitment process; including the setting in which recruitment will to place. → Provide copies of proposed recruitment materials (e.g., ads, flyers website postings, recruitment letters, and oral/written scripts): Once IRB approval is obtained, I will present my study to both care managers and hospitalists at their monthly meetings.

10. INCENTIVES TO PARTICIPATE

Will participants receive compensation or other incentives (e.g. fee services, cash payments, gift certificates, parking, classroom credit, travel reimbursement) to participate in the research study? →	☒ No	☐ Yes → **Describe the incentive, including the amount and timing of all payments:**

11. COSTS FOR PARTICIPATION

List any potential costs participants (or their insurers) will incur as a result of study participation (e.g., parking, study drugs, diagnostic tests): N/A

List any costs to participants that will be covered by the research study: **N/A**

12. INFORMED CONSENT PROCESS
Indicate the consent process(es) and document(s) to be used in the study. Check all that apply. Provide copies of the documents.

☐ Assent → **Complete IRB Form #22 – Permission to Participate Template**	
☐ Parental Permission → **Complete IRB Form #22 – Permission to Participate Template**	☐ Informed Consent → **Complete IRB Form #23 – Consent to Participate Template**
☐ Waiver or Alteration of Consent → **Complete IRB Form #7 – Request for Waiver of PHI Authorization and/or Waiver or Alteration of Informed Consent OR if the study does not involve the access, use, or disclosure of PHI → Complete IRB Form #8 – De-identification Certification**	☒ Waiver of Consent Documentation → **Complete IRB Form #7 – Request for Waiver of PHI Authorization and/or Waiver or Alteration of Informed Consent**

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Will any other tools (e.g., quizzes, visual aids, information sheets) be used during the consent process to assist participant comprehension?	☒ No	☐ Yes **Provide copies of these tools**
Will any other consent forms be used (e.g., for clinical procedures such as MRI, surgery, and/or consent forms from other institutions?	☒ No	☐ Yes **Provide copies of these tools**
Number of consent forms that will be used as part of the study: None		

13. HIPAA RESEARCH AUTHORIZATION

Will individually identifiable Protected Health Information (PHI) subject to the HIPAA Privacy Rule requirements be accessed, used, or disclosed in the research study?	☒ Yes **Check all that apply below**	☐ No **Complete IRB Form #8 – De-identification Certification**
☐ Written authorization	☐ Partial waiver (for subject identification only) **Complete IRB Form #7 – Request for Waiver of PHI Authorization and/or Waiver or Alteration of Informed Consent**	☒ Full waiver **Complete IRB Form #7 – Request for Waiver of PHI Authorization and/or Waiver or Alteration of Informed Consent**

14. PRINCIPAL INVESTIGATOR STATEMENTS

14a. COMPLIANCE

Have any of the Investigators received any notices of non-compliance from another IRB, the FDA, OHRP, and/or a sponsor/monitor in the last year?	☒ No	☐ Yes **Provide a copy of the notice**

14b. PRIOR REVIEW

Has the study been submitted to a non-AHS IRB and received a notice of disapproval?	☒ No	☐ Yes **Provide reason(s) for disapproval**

14c. FINANCIAL/NON-FINANCIAL INTEREST

Atlantic Health System has voluntarily adopted federal regulations on Objectivity in Research (42 CFR Part 50 Subpart F) as applicable to all research conducted at Atlantic Health System, regardless of funding source.

Indicate by marking **YES** or **NO** whether a financial interest exists. **This statement must be amended when necessary to reflect any changed circumstances, and must be resubmitted at the time of IRB continuing review.**

Is the study being submitted funded by an institution/organization/company?	**No** ☒ Section 14c is complete. **Response to the remaining questions is not required.** Sign and date the form.	**Yes** ☐ Answer all of the remaining questions in this section.
Do you and/or anyone in your immediate family hold a position of management within the institution/organization/company sponsoring the study being submitted? **"Immediate Family"** - Have a relationship to a person (whether by blood, law, or marriage) as a spouse, parent, child, grandparent, grandchild, stepchild, or sibling.	**No** ☒	**Yes** ☐ Complete and submit AHS IRB Form #34 – Financial/Non-Financial Interest Disclosure

Atlantic Health System

INSTITUTIONAL REVIEW BOARD
Request for Expedited Review (IRB Form-14)

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Do you and/or anyone in your immediate family have financial interest in the institution/organization/company sponsoring the study being submitted? **"Financial Interest"** - Anything of a monetary value including salary or other payments for services (such as consulting fees or honoraria), equity interests (such as stock, stock options, or other ownership valued at fair market value), intellectual property rights (patents, copyrights, royalties); or where the ownership interest constitutes more than 5% or the entity.	**No** ☒	**Yes** ☐ Complete and submit AHS IRB Form #34 – Financial/Non-Financial Interest Disclosure

14d. RESPONSIBILITIES and CERTIFICATIONS

I accept responsibility for ensuring adequate protection of the rights and welfare of all research subjects enrolled in the above study by:

(1) Complying with all Atlantic Health System Institutional Review Board guidelines, as well as federal and state regulations pertaining to protocol organization, conduct, and the consent process.
(2) Conducting the study in accordance with the relevant, current approved protocol and will only implement changes after IRB approval, except when necessary to protect the safety, rights, or welfare of the subjects.
(3) Promptly advising the IRB of any new information bearing on patient safety, any unanticipated problems, withdrawals from the study, and complaints by participants.
(4) Submitting, one month before the protocol's expiration date, a request for renewal or termination.
(5) Ensuring the appropriate training and conduct of all personnel involved in the study, and advising the IRB of any changes in personnel. This includes ensuring that all key personnel have completed an IRB-approved educational component in the protection of human subjects.
(6) Ensuring that all departments impacted by the study are duly notified.

I also certify that:

- I have read and understood the requirement to disclose financial/non-financial interest.
- I will file a new or updated Financial/Non-Financial Interests Disclosure form if the answer to any of the above questions changes.
- The answers to the declaration are accurate and truthful to the best of my knowledge.

Signature of the Principal Investigator	Print Name	Date
[signature]	PATRICIA BAXLEY	10/25/14

15. DEPARTMENT/INSTITUTIONAL APPROVAL

I have reviewed this protocol and attest that the Principal Investigator has the qualifications and adequate resources to undertake the research described. I support the performance of this investigation.

Department or Division: Nursing

Signature of Department Head/ Medical Director	Print Name	Date

Atlantic Health System

INSTITUTIONAL REVIEW BOARD
Request for Expedited Review (IRB Form-14)

Handwritten forms will not be accepted

The signature of the Medical Director of the Atlantic Center for Research is required if any of the study personnel is also the Department Head.

Medical Director, Atlantic Center for Research (if required):

Signature	Print Name	Date

A study will not be considered eligible for review unless a complete submission package is submitted.

A submission is considered complete once all of the following applicable items are submitted:

- ✓ The Application completed with **all** required signatures
- ✓ Investigator facesheet completed by each sub-investigator (including Clinical Research Coordinators)
  - Complete and submit Financial Disclosure form (if applicable)
- ✓ **1 copy** of the Protocol (including all questionnaires, surveys, or participant information sheets, if applicable)
- ✓ **1 copy** of the Informed Consent Document in Atlantic Health System format (if applicable)
- ✓ All recruitment materials
- ✓ Curriculum Vitae of investigators **(unless previously on file)**
- ✓ Completion of human subject protection training for all key research personnel **(unless previously on completed)**
- ✓ One copy of the entire grant submission (for all federally funded research).
- ✓ If this is a funded study, the Clinical Trial agreement and budget must be submitted to the Atlantic Center for Research

Appendix K
IRB Study Modification Approval and Application

Atlantic Health System

Institutional Review Board
475 South Street
Morristown, NJ 07960
Phone: (973) 660-3128
Fax: (973) 292-7923

Morristown Medical Center
Overlook Medical Center
Newton Medical Center
Chilton Medical Center
Goryeb Children's Hospital

TO:	Patricia Baxter, MSN
PROJECT TITLE:	[669230-2] Satisfaction with Communication from Hospitalists
REFERENCE #:	
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED
APPROVAL DATE:	12/10/14
EXPIRATION DATE:	11/24/15
REVIEW TYPE:	Expedited

The submission reviewed for above-referenced protocol has received approval based on applicable federal regulations.

No investigator involved in the above referenced protocol participated in the vote to approve the study.

The following items were reviewed with this submission:

- Amendment/Modification - Change in Survey (UPDATED: 12/9/2014)
- Letter - Summary of change (UPDATED: 12/9/2014)
- Protocol - Protocol REVISED 12.9.2014 (UPDATED: 12/9/2014)
- Questionnaire/Survey - Revised Survey (1 less question) (UPDATED: 12/9/2014)

The following items were approved with this submission:

- Protocol - Protocol REVISED 12.9.2014
- Questionnaire/Survey - Revised Survey (1 less question)

Report all events that are unanticipated problems, unanticipated problems, which are also adverse events, deaths occurring in subjects enrolled at an AHS facility, and deviations from the approved protocol that would place the subject at greater risk than anticipated, to the AHS IRB in writing immediately.

The Food and Drug Administration Amendment Act of 2007 requires that Phase II-IV trials of drugs and biologics and trials of devices be registered in ClinicalTrials.gov. The responsibility of registering these trials falls on the sponsor of the trials and/or the Principal Investigator. If you are conducting an "Investigator-initiated" study that fits the criteria above, you must register. If you are conducting a sponsored trial fitting the criteria, you must ensure that the sponsor registers.

Modifications to the study must be submitted in writing and approved by the AHS IRB prior to implementation of the changes.

Investigators are required (by Federal Regulations) to submit reports on the status and/or results of clinical studies approved by the AHS IRB. For the above-referenced study, status/result reports will be due on the basis indicated above and/or within 30 days of the termination of the investigation. It is the Principal Investigator's responsibility to secure continuing approval or notify the AHS IRB of termination of the study.

No subjects may be enrolled into this study after the above expiration date unless a continuation report is submitted and approved by the AHS IRB.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Atlantic Health System IRB's records.

Atlantic Health System

INSTITUTIONAL REVIEW BOARD
Study Modification Request
(IRB Form-4)

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Study modifications may not be implemented until written approval from the AHS IRB is obtained, except when necessary to protect the safety, rights, or welfare of the subject(s).

1. PROJECT INFORMATION

Date of report: 12/9/2014	IRB Number: 669230-1
Title: Patient Satisfaction with Communication from Hospitalists at Morristown Medical Center	
Sponsor: N/A	Sponsor's Protocol Number/Name: N/A
If this is a sponsored study, by whom was the modification initiated?	☐ Sponsor ☒ Principal Investigator
If this is a PI initiated modification, has the sponsor been notified of the change?	☐ Yes ☒ No → **Explain: N/A**

2. PRINCIPAL INVESTIGATOR (PI)

Name: Patricia Baxter	Degree(s): RN, MSN
Office Phone #: [redacted]	Mobile Phone #: [redacted]
Email: patricia.baxter@atlantichealth.org	Fax: 973-267-[redacted]
Substitute PI: (In the event the PI is unavailable for an extended period of time)	

2a. STUDY CONTACT
Individual to contact in addition to the PI to address any study related questions (e.g. Clinical research coordinator).

Name: N/A	
Email:	Phone:

3. PROJECT STATUS
Check the box that represents the enrollment status of the research project? Check only one box

☒ Open/Active ***Subjects are being enrolled***	☐ Closed ***Subjects are still receiving study drug/intervention***	☐ Closed ***Subjects have completed study drug/intervention, but continue to be followed***

Total number of subjects currently enrolled in the study: 0

4. PROPOSED STUDY MODIFICATION
Check the box that describes the proposed change(s). Check all that apply.

☐ Addition of study personnel →	**Provide the name(s) and submit sub-investigator facesheet if applicable:**
☐ Removal of study personnel →	**Provide the name(s):**
☒ Changes to the protocol →	**Attach the revised protocol and briefly describe the changes: 1 question has been removed from the study survey**
☐ Enrollment increase →	**Provide proposed number:**
☐ Changes to the consent form → **Submit the revised document with changes highlighted**	☐ Changes to the number of consent forms used in the study → **Submit the proposed new document**
☐ Addition of or revisions to recruitment material → **Submit recruitment material** →	

Atlantic Health System

INSTITUTIONAL REVIEW BOARD
Study Modification Request
(IRB Form-4)

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☐ Other **Describe:**

4a. TYPE OF CHANGE
The modification involves what type of change to the previously approved study?
If the modification involves more than one change and both degrees, check the SUBSTANTIVE box only.

☒ **MINOR**	☐ **SUBSTANTIVE**
Modification may qualify for Expedited Review **Examples of minor changes are:** • Changes in research personnel that do not alter the competence of the research team to conduct the research • Scientific and/or therapeutic changes that leave the research population at the same or lower risk than risk(s) already approved • A minor increase or decrease in the number of participants (<25% change) • Changes in the amount and frequency of blood draws (which remain within the expedited criteria) • Addition of a clinic visit that involves no new procedures • Addition of a questionnaire that does not introduce new subject matter • An increase in the number of study visits for the purpose of increased safety monitoring • Minimal changes in subject compensation • Changes to improve the clarity of statements, enhance comprehension or to correct typographical errors, updating to current template, without altering the content or intent of the statement • Clarification of discrepancies within the IRB review materials	***Modification requires full board review*** **Examples of substantive changes that are:** • Knowledge of a new risk which might affect the risk/ benefit ratio • Increasing the dose/strength of an investigational drug • Changing the originally targeted population to include a more at-risk population • Adding additional procedures where the risk of the additional procedure is greater than minimal risk • Adding a blood draw such that the total amount of blood drawn or frequency of blood draws exceeds the amount allowed by the expedited criteria • Adding an element that may breach the confidentiality of the subject such as tissue banking or genetic testing • An increase >25% in the number of participants to be "treated" • Requesting surrogate consent for a previously approved study • Additional exposure to radiation as part of the study (i.e. additional x-rays, DEXA scans)

4b. ADDITIONAL RISK
Check the box that best describes the degree of risk to subjects. Check at least one.

Does the modification involve increased risk to participants? ➔	☒ No ☐ Yes ➔ **Explain:**
Does the modification provide new information about additional risk? ➔	☒ No ☐ Yes ➔ **Explain:**

4c. NEW INFORMATION

Does the proposed modification involve new information that will be distributed to subjects previously enrolled (i.e. will the new information influence their decision of whether or not to continue participation)?	☒ No		
	☐ Yes ➔	☐ Informational Letter	☐ Re-consenting subjects using a revised consent form

Patricia Baxter — **Signature of the Principal Investigator**

PATRICIA BAXTER — **Print Name**

12/9/14 — **Date**

Atlantic Health System

INSTITUTIONAL REVIEW BOARD
Study Modification Request
(IRB Form-4)

Handwritten forms will not be accepted

A submission is considered complete once all of the following applicable items are submitted:

- ✓ The Study Modification form completed with required signature
- ✓ **1 copy** of the current dated version of the protocol (if applicable)
- ✓ **1 copy** of the revised informed consent document (with proposed changes **highlighted**) (if applicable)
  - And a revised copy with the changes **not highlighted**
- ✓ For modifications adding study personnel
  - Curriculum Vitae of Investigators (unless previously on file)
  - Completion of CITI training (unless previously completed)
  - Completion of Federal Funds Compliance training (unless previously completed)
- ✓ Additional or revised recruitment material
- ✓ Copy of **Other** proposed changes as indicated in section 4

Bibliography

Accreditation Council for Graduate Medical Education (ACGME). http://www.acgme.org.

_____ . "*ACGME Common Program Requirements."* ACGME approved focused revision: June 9, 2013; effective: July 1, 2013: 10.

Agency for Healthcare Research and Quality. http://archive.ahrq.gov/news/newsroom/press-releases/2011/questions.html.

Ahronheim, Judith, Jonathan D. Moreno, and Connie Zuckerman. *Ethics in Clinical Practice.* Sudbury: Jones and Bartlett Publishers, 2005.

American Academy of Family Physicians. http://www.aafp.org/online/en/home/aboutus.html?navid=about+us.

American Academy of Physician Assistants. http://www.aapa.org/twocolumnmain.aspx?id=290.

American Association of Nurse Practitioners. http://www.aanp.org/all-about-nps.

American Board of Medical Specialties (ABMS). http://www.abms.org/.

American College of Physicians (ACP). http://www.acponline.org/about_acp/.

American Hospital Association (AHA). http://www.aha.org.

Atlantic Health. http://www.atlantichealth.org.

Auerbach, Andrew D., Elizabeth A. Nelson, Peter K. Lindenauer, Steven V. Pantilat, Patricia P. Katz, and Robert M. Wachter. "Physician Attitudes Toward and Prevalence of the Hospitalist Model of Care: Results of a National Survey." *The American Journal of Medicine* 109 (2000): 648-653.

Barnett, Peter B. "Rapport and the Hospitalist." *The American Journal of Medicine* 111, no. 9 (December, 21 2001): 31-40.

Baudendistel, Thomas E. and Robert M. Wachter. "The Evolution of the Hospitalist Movement in the USA." *Clinical Medicine* 2, no. 4 (July/August 2002): 327-330.

Bell, Chaim M., Jeffrey L. Schnipper, Andrew D. Auerbach, Peter J. Kaboli, Tosha B. Wetterneck, David V. Gonzales, Vineet M. Arora, James X. Zhang, and David O. Meltzer. "Association of Communication Between Hospital-based Physicians and Primary Care Providers with Patient Outcomes." *Journal of General Internal Medicine* (2008): 381-386.

Centers for Medicare and Medicaid Services. http://www.cms.gov.

Chen, Lena M., John D. Birkmeyer, Sanjay Saint, and Ashish K. Jha. "Hospitalist Staffing and Patient Satisfaction in the National Medicare Population." *Journal of Hospital Medicine* 8, no. 3 (March 2013): 126-131.

Coleman, Eric A. and Mark V. Williams. "Executing High-Quality Care Transitions: A Call To Do It Right." *Journal of Hospital Medicine* 2 (2007): 287-290.

Conway, Patrick H. "Value-Driven HealthCare: Implications for Hospitals and Hospitalists." *Journal of Hospital Medicine* 4, no. 8 (October 2009): 507–511.

Cruse, Audrey. *Roman Medicine.* Great Britain: Tempus Publishing Ltd., 2006.

Darr, Kurt. *Ethics in Health Services Management, 4th Ed*. Baltimore: Health Professionals Press, 2005.

Davis, Kenneth M., Karen E. Koch, J. Ken Harvey, Renee Wilson, Jan Englert, and Patrick D. Gerard. "Effects of Hospitalists on Cost, Outcomes, and Patient Satisfaction in a Rural Health System." *The American Journal of Medicine* 108 (June 1, 2000): 621-626.

Fernandez, Alicia, Kevin Grumbach, Lara Goitein, Karen Vranizan, Dennis H. Osmond, and Andrew B. Bindman. "Friend or Foe? How Primary Care Physicians Perceive Hospitalists." *Archives of Internal Medicine 160* (October 23, 2000): 2902 – 2908.

Ferranti, Darlene, Gregory Makoul, Victoria Forth, Jennifer Rauworth, Jungwha Lee, and Mark V. Williams. "Assessing Patient Perceptions of Hospitalist Communication Skills Using the Communication Assessment Tool (CAT)." *Journal of Hospital Medicine* 5, no. 9 (November/December 2010): 522-527.

Freed, David H. "Hospitalists: Evolution, Evidence, and Eventualities." *The Health Care Manager* 23, no.3 (July-September 2004): 238-256.

Fulton, Bradley R., Kathryn E. Drevs, Louis J. Ayala, and Donald L. Malott. "Patient Satisfaction with Hospitalists: Facility-Level Analysis." *American Journal of Medical Quality* 26, no. 2 (March/April 2011): 95-102.

Geehr, Edward C. and John R. Nelson. "Hospitalists: Who They Are and What They Do." *Physician Executive* 28, no 6 (November/December 2002): 26-31.

Goldman, David R. "The Hospitalist Movement in the United States: What Does it Mean for Internists?" *Annals of Internal Medicine* 130, no. 4 (February 16, 1999): 326-327.

Goldman, Lee. "Hospitalists as Cure for Hospitalism." *Transactions of the American Clinical and Climatological Association* 114 (2003): 37-50.

Goldman, Lee, Steven Z. Pantilat, and Winthrop F. Whitcomb. "Passing the Clinical Baton: 6 Principles to Guide the Hospitalist." *The American Journal of Medicine* 111 (December 2001): 36S-39S.

Halasyamani, L., S Kripalani, E. Coleman, J. Schnipper, C. vanWalraven, J. Nagamine, P. Torscon, T. Bookwalter, T. Budnitz, and D. Manning. "Transition of Care for Hospitalized Elderly Patients – Development of a Discharge Checklist for Hospitalists." *Journal of Hospital Medicine* 1, no. 6 (November/December 2006): 354-360.

Hippocratic Oath. *Harvard Classics* 38, Boston: P.F. Collier and Son, 1910.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). http://hcahpsonline.org/home.aspx.

Hruby Milena, Steven Z . Pantilat, and Bernard Lo. "How do Patients View the Role of the Primary Care Physician in Inpatient Care?" *The American Journal of Medicine* 111, issue 9, S2 (December 21, 2001): 21-25.

Hulsman, Robert, Adriaan Visser, and Gregory Makoul. "Addressing Some of the Key Questions About Communication in Health Care." *Patient Education and Counseling* 58 (October 2005): 221-224.

Institute of Medicine. http://www.iom.edu/Reports.aspx.

Joint Commission. http://www.jointcommission.org/standards_information/npsgs.aspx.

Kavic, Michael S., "Competency and the Six Core Competencies," *Journal of the Society of Laparoendoscopic Surgeons* 6, no. 2 (April-June 2002): 95-97.

Korsch, Barbara M., Ethel K. Gozzi, and Vida Francis. "Gaps in Doctor-Patient Communication: Doctor-Patient Interaction and Patient Satisfaction." *Pediatrics* 42, no. 5 (November 1968): 855-871.

Kongstvedt, Peter R. *Essentials of Managed Health Care, 6th Ed.* Massachusetts: Jones and Bartlett Learning, 2013.

Kralovec, Peter D., Joseph A. Miller, Laurence Wellikson, and Jeanne M. Huddleston. "The Status of Hospital Medicine Groups in the United States." *Journal of Hospital Medicine* 1, no. 2 (March/April 2006): 75-80.

Kripalani, Sunil, Amy T. Jackson, Jeffrey L. Schnipper, and Eric A. Coleman. "Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists." *Journal of Hospital Medicine* 2 (Sept/Oct 2007): 314-323.

Kripalani, Sunil, Frank LeFevre, Christopher O. Phillips, Mark V. Williams, Preetha Basaviah, and David W. Baker. "Deficits in Communication and Information Transfer Between Hospital-based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care." *Journal of American Medical Association* 297, no. 8 (February 28, 2007): 831-841.

Kulaga, Mark E., Pamela Charney, Stephen P. O'Mahony, Joseph P. Cleary, Timothy M. McClung, and Donald E. Schildkamp. "The Positive Impact of Initiation of Hospitalist Clinician Educators: Resource Utilization and Medical Resident Education." *Journal of General Internal Medicine* 19 (April 2004): 293-301.

Lasagna, Louis. *Hippocratic Oath (Modern Version)*. Massachusetts: Tufts University, 1964.

Lee, Kheng Hock. "The Hospitalist Movement – A Complex Adaptive Response to Fragmentation of Care in Hospitals." *Annals Academy of Medicine* 37, no.2 (February 2008): 145-150.

Levinson, Wendy. "Physician-Patient Communication: A Key to Malpractice Prevention." *Journal of the American Medical Association* 272, no. 20 (November 1994): 1619-1620.

Levinson, Wendy, Debra L. Roter, John P. Mullooly, Valerie T. Dull, and Richard Frankel. "Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons." *Journal of the American Medical Association* 277, no. 7 (February 1997): 553-559.

Lindenauer, Peter K., Steven Z. Pantilat, Patricia P. Katz, and Robert M. Wachter. "Hospitalists and the Practice of Inpatient Medicine: Results of a Survey of the National Association of Inpatient Physicians." *Annals of Internal Medicine* 130 (February 1999): 343- 349.

Lo, Bernard. "Ethical and Policy Implications of Hospitalist Systems." *The American Journal of Medicine* 111 (December 2001): 48-52.

Loewy, Erich H. and Roberta Springer Loewy. *Textbook of Healthcare Ethics 2nd ed.* Boston: Kluwer Academic Publishers, 2003.

Lurie, Jon D., David P. Miller, Peter K. Lindenauer, Robert M. Wachter, and Harold C. Sox. "The Potential Size of the Hospitalist Workforce in the United States." *The American Journal of Medicine* 106 (April 1999): 441-445.

Makoul, Gregory. "The Interplay Between Education and Research About Patient-Provider Communication." *Patient Education and Counseling* 50 (May 2003): 79-84.

Makoul, Gregory and Raymond H. Curry. "The Value of Assessing and Addressing Communication Skills." *Journal of the American Medical Association* 298, no. 9 (September 5, 2007): 1057-1059.

Makoul, Gregory, Edward Krupat, and Chih-Hung Chang. "Measuring Patient Views of Physician Communication Skills: Development and Testing of the Communication Assessment Tool." *Patient Education and Counseling* 67, no.3 (August 2007): 333-342.

McAlearney, Ann Scheck. "Hospitalists and Family Physicians: Understanding Opportunities and Risks." *Journal of Family Practice* 53 (June 2004): 473-481.

McCarthy, Danielle M., Emily P. Ellison, Arjun K. Venkatesh, Kirsten G. Engel, Kenzie A. Cameron, Gregory Makoul, and James G. Adams. "Emergency Department Team Communication with the Patient: The Patient's Perceptive." *Journal of Emergency Medicine* 45, no. 2 (February 20, 2012): 262-270.

Mechanic, David and Mark Schlesinger. "The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians," *Journal of the American Medical Association* 275, no. 21 (June 5, 1996): 1693-1697.

Mercer, Laura Min, Paula Tanabe, Peter S. Pang, Michael A. Gisondi, D. Mark Courtney, Kirsten G. Engel, Sarah M. Donlan, James G. Adams, and Gregory Makoul. "Patient Perspectives on Communication with the Medical Team: Pilot Study using the Communication Assessment Tool-Team (CAT-T)." *Patient Education and Counseling* 73, no. 2 (November 2008): 220-223.

Moore, Gordon and Jonathan Showstack. "Primary Care Medicine in Crisis: Toward Reconstruction and Renewal." *Annals of Internal Medicine* 138, no.3 (February 4, 2003): 244-247.

Myerholtz, Linda, Lynn Simons, Sumi Felix, Tuan Nguyen, Julie Brennan, Ana Rivera-Tovar, Pat Martin, Jeri Hepworth, and Gregory Makoul. "Using the Communication Assessment Tool in Family Medicine Residency Programs." *Family Medicine* 42, no. 8 (September 2010): 567-573.

National Institutes of Health. http://www.nlm.nih.gov/medlineplus/ency/article/001939.htm.

Newman, David H. *Hippocrates' Shadow: Secrets from the House of Medicine.* New York: Scribner, 2008.

O'Leary, Kevin J., Tiffani A. Darling, Jennifer Rauworth, and Mark V. Williams. "Impact of Hospitalists Communication-Skills Training on Patient Satisfaction Scores." *Journal of Hospital Medicine* 8, no. 6 (June 2013): 315-320.

O'Leary, Kevin J., David M. Liebovitz, and David W. Baker. "How Hospitalists Spend Their Time: Insights on Efficiency and Safety." *Journal of Hospital Medicine* 1, no. 2 (March/April 2006): 88-93.

O'Leary, Kevin J. and Mark V. Williams. "The Evolution and Future of Hospital Medicine." *Mount Sinai Journal of Medicine* 75, no. 5 (October 2008): 418-423.

Pantilat, Steven Z., Ann Alpers, and Robert M. Wachter. "A New Doctor in the House: Ethical Issues in Hospitalist Systems." *Journal of the American Medical Association* (July 1999): 171-174.

Pantilat, Steven Z., Peter K. Lindenauer, Patricia P. Katz, and Robert M. Wachter. "Primary Care Physician Attitudes Regarding Communication with Hospitalists." *The American Journal of Medicine* 111 (December 21, 2001): 15S-20S.

Pellegrino, Edmund D. and David C Thomasma. *The Virtues in Medical Practice.* New York: Oxford University Press, 1993.

Peterson, Michael C. "A Systematic Review of Outcomes and Quality Measures in Adult Patients Cared for by Hospitalists vs Non-hospitalists." *Mayo Clinic Proceedings* 84, no. 3 (March 2009): 248-254.

Press Ganey Associates, Inc. http://www.pressganey.com.

Rosenbloom, Adam Haley and Alan Jotkowitz. "The Ethics of the Hospitalist Model." *Journal of Hospital Medicine* 5 (March 2010): 183-188.

Rothberg, Michael B., John R. Steele, John Wheeler, Ashish Arora, Aruna Priya, and Peter K. Lindenauer. "The Relationship Between Time Spent Communicating and Communication Outcomes on a Hospital Medicine Service." *Journal of General Internal Medicine* (September 16, 2011): 185-189.

Roy, Christopher L., Eric G. Poon, Andrew S. Karson, Zahra Lada-Merchant, Robin E. Johnson, Saverio M. Maviglia, and Tejal K. Gandhi. "Patient Safety Concerns Arising From Test Results That Return After Hospital Discharge." *Annals of Internal Medicine* 143, no. 2 (July 19, 2005): 121-128.

Saint, Sanjay and Scott Flanders. "Hospitalists in Teaching Hospitals: Opportunities But Not Without Danger." *Journal of General Internal Medicine* 19 (April 2004): 392-393.

Scalise, Dagmara. "Hospitalist: In-house Docs Can Ease Some Vexing Problems, But First You've got to Win over the Skeptics." *Hospital and Health Networks Magazine* (June 2006): 56-60.

Seiler, Adrianne, Paul Visintainer, Richard Brzostek, Michael Ehresman, Evan Benjamin, Winthrop Whitcomb, and Michael B. Rothberg. "Patient Satisfaction with Hospital Care Provided by Hospitalists and Primary Care Physicians." *Journal of Hospital Medicine* 7, no.2 (February 2012): 131-136.

Simon, Steven R., Thomas H. Lee, Lee Goldman, Allison McDonough, and Steven D. Pearson. "Communication Problems for Patients Hospitalized with Chest Pain." *Journal of General Internal Medicine* 13 (December 1998): 836-838.

Society of Hospital Medicine. http://www.hospitalmedicine.org.

Stewart, Moira, Judith Belle Brown, Heather Boon, Joanne Galajda, Leslie Meredith, and Michelle Sangster. "Evidence on Patient-Doctor Communication." *Cancer Prevention and Control* 3, no. 1 (February 1999): 25-30.

Street, Richard L., Gregory Makoul, Neeraj K. Arora, and Ronald M. Epstein. "How Does communication Heal? Pathways Linking Clinician-Patient Communication to Health Outcomes." *Patient Education and Counseling* 74, no. 3 (March 2009): 295-301.

Terry, Ken. "Can Hospitalists Cross the Quality Chasm?" *Hospital and Health Networks Magazine* (June 2008): 52-56.

——— ."The Changing Face of Hospital Practice." *Medical Economics* (August 2002): 73-79.

——— . "Hospitalist: Communication is Key." *Medical Economics* (September 2005): 27-30.

Thrall, Teresa Hudson. "Hospitalists: A Specialty Coming into Its Own." *Hospital and Health Networks Magazine* (November 2003): 66-70.

Tipping, Matthew D., Victoria E. Forth, Kevin J. O'Leary, David M. Malkenson, David B. Magill, Kate Englert, and Mark V. Williams. "Where Did the Day Go? – A Time-Motion Study of Hospitalists." *Journal of Hospital Medicine* 5, no. 6 (July/August 2010): 323-328.

US Department of Health and Human Services Agency for Healthcare Research and Quality. http://www.ahrq.gov/patients-consumers/care-planning/errors/20tips/index.html.

vanWalraven, Carl, Ratika Seth, and Andreas Laupacis. "Dissemination of Discharge Summaries, Not Reaching Follow-up Physicians." *Canadian Family Physician 48* (April 2002): 737-742.

Wachter, Robert M. "The Evolution of the Hospitalist Model in the United States." *The Medical Clinics of North America* 86 (July 2002): 687-706.

———. "An Introduction to the Hospitalist Model." *Annals of Internal Medicine* 130, no. 4 (February 16, 1999): 338-342.

Wachter, Robert M. and Lee Goldman. "The Emerging Role of 'Hospitalists' in the American Healthcare System." *The New England Journal of Medicine* 335 (August 15, 1996): 514-517.

———. "The Hospitalist Movement Five Years Later." *Journal of the American Medical Association* 287, no. 4 (January 23, 2002): 487-494.

Wachter, Robert, Lee Goldman, and Harry Hollander. *Hospital Medicine.* Philadelphia: Lippincott Williams & Wilkins, 2000.

Wachter, Robert M., Patricia Katz, Jonathan Showstack, Andrew B. Bindman, and Lee Goldman. "Reorganizing and Academic Medical Service: Impact on Cost, Quality, Patient Satisfaction, and Education." *Journal of the American Medical Association* 279, no. 19 (May 20, 1998): 1560-1565.

Williams, Mark V. "The Future of Hospital Medicine: Evolution or Revolution?" *The American Journal of Medicine* 117 (September 15, 2004): 446-450.

Zolnierek, Kelly B.Haskard and M. Robin DiMatteo. "Physician Communication and Patient Adherence to Treatment: A Meta-analysis." *Medical Care* 47, no. 8 (August 2009): 826-834.

VITA

Full name: Patricia Baxter

Place and date of birth: New York; 05/04/1966

Parents Name: Edward and Mary Ross

Educational Institutions:

School	Place	Degree	Date
Secondary: Boonton High School	Boonton, NJ	High School	June 1984
Collegiate: William Paterson University	Wayne, NJ	BSN	May 1988
Graduate: Seton Hall University	South Orange, NJ	MSN	May 1998
Drew University	Madison, NJ	DMH	May 2015