REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-16

Subject: Physician Communication and Care Coordination During Patient Hospitalizations (Resolution 714-A-15)

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee G
(Steven Hattamer, MD, Chair)

At the American Medical Association's (AMA) 2015 Annual Meeting, the House of Delegates referred Resolution 714-A-15, which was sponsored by the Organized Medical Staff Section (OMSS). Resolution 714-A-15 asked:

> That our AMA advocate that hospital admission processes should include: (1) a determination of whether the patient has an existing relationship with a primary care physician; and (2) prompt notification of the patient's primary care physician, where such a relationship is found to exist and where the patient does not object to such notification.

At the 2015 Interim Meeting, the House of Delegates adopted Policy H-225.946, which asks:

> 1. That our AMA and the Organized Medical Staff Section (OMSS) advocate that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; prompt notification of such actively treating physician(s) where such a relationship exists; notice to the patient that he/she may request admission and treatment by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges. 2. That our AMA and the OMSS advocate that a medical staff incorporate the above principles into medical staff bylaws, rules and regulations. 3. That our AMA request that the AMA Litigation Center be alert for opportunities to challenge and the Advocacy Resource Center study and address the trend of hospitals' use of their employed hospitalists to limit the rights of their non-employed medical staff to admit and treat patients.

The Board of Trustees assigned the third clause of Policy H-225.946 and referred Resolution 714-A-15 to the Council on Medical Service. This report provides background on physician communication and care coordination during patient hospitalizations, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

The goals of referred Resolution 714-A-15 and Policy H-225.946 are to preserve physician-patient relationships; improve communication and collaboration between hospital-based physicians and patients' other treating physicians during hospitalizations; and ensure that appropriately credentialed community physicians can admit and follow their hospitalized patients if they want to

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do so. Policy H-225.946 is intended to enhance care coordination as well as patient safety, quality, and satisfaction. Suboptimal communication between attending and treating physicians can lead to fragmented care, unnecessary testing and treatment, and potentially more costly hospitalizations or post-discharge problems. Conversely, good communication among hospital-based and community physicians results in more seamless, high-value care.

Before the advent of hospitalists and growth in the hospital medicine specialty, primary care physicians (PCPs) typically admitted and followed their patients during hospital stays, or took turns covering a practice's hospitalized patients. A recent editorial in the New England Journal of Medicine (NEJM) calls the "near disappearance of PCPs from general medical inpatient care" one of the most significant changes in health care delivery in the past 25 years.[1] A number of factors have fueled this transformation, including higher levels of acuity in the acute care setting as well as pressures for efficiencies in both inpatient and outpatient care.[2] In addition, community physicians who determine that providing inpatient care is not cost-effective or that it interferes with their office-based practice have embraced this change. Referred Resolution 714-A-15 and Policy H-225.946 raise concerns regarding episodic lapses in communication between hospital-based physicians and patients' other treating physicians during patient hospitalizations.

Surveys and observational studies have found that a significant number of PCPs do not know about the hospitalization of their patients, and those patients whose PCPs are unaware of their admission are more likely to report post-discharge problems. [3,4,5] Hospitalists have reported that community physicians do not always alert them about patients needing hospitalization, or provide limited medical histories on hospitalized patients.[6] Lack of time, difficulty reaching providers in the other setting, lack of personal relationships among hospital and non-hospital providers, and a lack of routine communication between health systems have been identified as contributors to lapses in communication among hospitalists and PCPs.[7] In addition, patients may be unable to identify a treating physician upon admission or incorrectly report a non-treating physician to the hospital team. These studies highlight variability in the extent of communication between inpatient and outpatient physicians and the need for two-way exchanges.

Testimony at I-15 described anecdotal instances of hospitals failing to notify non-hospital-based treating physicians that their patients were hospitalized, or preventing physicians from seeing their patients while hospitalized. To carry out the third clause of Policy H-225.946, the Council requested feedback from the Federation to better understand the prevalence of these practices. Nearly all respondents indicated that they had not heard complaints regarding hospitals preventing on-staff, credentialed physicians from seeing their hospitalized patients. Two physicians reported that hospitalists had preferentially notified physicians other than the patient's treating physician about a hospital admission, and that they had been prevented from participating in their patients' hospitalized care. Clinical privileges were not at issue, and these physicians became aware of their patients' hospitalizations only when they were contacted directly by patients or their families. It is important to note that these were isolated incidences specific to particular hospitals.

The Society of Hospital Medicine (SHM), which is the national medical specialty society representing hospitalists, supports as policy an open medical staff and the ability of all credentialed and qualified physicians to admit their patients. Hospitals generally recognize a patient's right to have a PCP promptly notified of his or her admission to the hospital, and a review of hospital policies found that patients are generally informed that their PCP is welcome to communicate with the hospitalist throughout their hospital stay.

Models Promoting Physician Communication and Payment for Interprofessional Consultations

Models designed to bridge the divide between inpatient and outpatient care have been described in the literature. A recent *JAMA Viewpoint* discusses two delivery models in which hospitalists lead team-based care provided to high-risk elderly patients in both inpatient and outpatient settings.[8] Under the "comprehensive care" and "extensivist" models, a single physician—a hospitalist—is responsible for patients across inpatient and ambulatory sites of care.[9]

A model in which PCPs participate as consultants to hospitalist teams was described in a 2015 NEJM editorial.[10] Barriers to this collaborative inpatient care model include the time burden placed on participating PCPs and payment policies that do not adequately compensate physicians for providing collaborative inpatient care. To this point, the American Academy of Family Physicians has asked Centers for Medicare & Medicaid Services (CMS) and seven of the large private health insurers to revise their payment and coverage policies to "recognize ambulatory primary care physicians as specialists for the purposes of consulting on their hospitalized patients and to allow for payment when a consultation is requested from the patient's PCP by a hospitalist or specialist attending physician."[11] Similarly, the American College of Physicians has recommended that CMS pay for electronic consultations both between hospitalists and PCPs and specialists and PCPs.[12] In 2014, the CPT Editorial Panel created four CPT codes to describe interprofessional telephone/internet consultative services (CPT Codes 99446-99449); however, Medicare does not currently provide separate payment for these codes. Our AMA strongly supports recognizing these services and establishing Medicare payments to physicians for consulting with each other on patient care. These payments would facilitate collaboration among patients' treating physicians—including PCPs, medical specialists, surgeons and other hospital-based physicians—on care and treatment planning for individual patients, including those who are hospitalized.[13]

Future HIT and Telehealth Solutions

In the future, advances in the fields of health information technology (HIT) and telemedicine will likely ameliorate some of the concerns that are the focus of Resolution 714-A-15 and Policy H-225.946. More widespread use of direct messaging capabilities, such as admit/discharge/transfer (ADT) messaging, will enable hospitals to alert community physicians when one of their patients is hospitalized. Health information exchanges (HIEs) provide the ability for electronic health records (EHRs) to "subscribe" to ADT messaging. However, many barriers remain, including HIE interface costs, EHR capabilities, and HIE networks that are unable to talk to each other. The AMA continues to advocate for interoperability cornerstones, including the need for patient matching, provider directories, more guidance on privacy and security and standardized clinical vocabularies that will make state-of-the-art ADT messaging a reality. Similarly, maturation in the field of telemedicine and ongoing expansion of who may furnish and receive payment for telehealth consults may make virtual hospital visits more standard.

AMA POLICY

The actions requested by Resolution 714-A-15 were largely accomplished by adoption of Policy H-225.946 at the 2015 Interim Meeting. Additional policy recognizes the importance of effective communication between hospitals and referring primary care physicians. Policy D-160.945 directs the AMA to advocate for timely and consistent inpatient and outpatient communications among hospital and hospital-based physicians and the patient's primary care referring physician, including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety. Policy D-160.945

also directs the AMA to explore new mechanisms to facilitate and incentivize communication and transmission of data for timely coordination of care between hospital-based physicians and PCPs.

In addition, the AMA has extensive policy on the voluntary use of hospitalists, including Policies H-225.960 and H-285.964. Policy H-225.960 states that the use of a hospitalist as the physician of record during a hospitalization must be voluntary, and the assignment of responsibility to the hospitalist must be based on the consent of the patient's personal physician and the patient. AMA policy also opposes any hospitalist model that disrupts the patient-physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants (Policy H-285.964). More broadly, the AMA supports free choice by patient and physician (Policy H-330.988).

Medical staffs are encouraged to develop medical staff membership categories for physicians who provide a low-volume or no volume of clinical services in the hospital under Policy H-225.949, which also encourages medical staffs to engage community physicians in hospital activities, including transitions of care initiatives and professional and collegial events.

AMA RESOURCES

The granting of hospital clinical privileges is generally enumerated in hospital medical staff bylaws. The AMA's Physician's Guide to Medical Staff Organization Bylaws (Physician's Guide), a reference manual for drafting or amending medical staff bylaws, includes sample bylaw language on clinical privileges, self-governance and other issues relevant to hospital-medical staff relationships. Free to AMA members, the Physician's Guide describes elements that should be included in any medical staff bylaws.

The AMA worked with the SHM, the American Hospital Association and The Joint Commission to develop Principles for Developing a Sustainable and Successful Hospitalist Program, which are appended to the Physician's Guide. The Principles emphasize shared accountability for patients among hospitalists and community physicians, stating that "both parties must be diligent to assure that key information (medications, test results, follow up requirements, etc.) is transmitted and acted upon in a clear and timely fashion. During the hospitalization, the hospitalist needs to communicate to the PCP if there are significant changes in the patient's condition; the PCP should be accessible if any new issues arise that may require further input or information."[14]

DISCUSSION

The Council concurs that communication and coordination among physicians during patient hospitalizations is essential to the provision of safe, high-quality, and personalized care. This is especially true at a time when a preponderance of hospital care is overseen by the more than 50,000 hospitalists currently practicing in the United States, and as community physicians increasingly choose not to care for their patients in the hospital setting. Accordingly, the Council recommends reaffirming Policy D-160.945, which addresses communication between hospitals and primary care referring physicians, and Policy H-225.949, which encourages engagement of community physicians by medical staffs around care transitions and other activities.

Community physicians who are aware of their patients' hospitalizations are better prepared to provide appropriate post-discharge follow-up. Accordingly, the Council supports universal notification of patient hospitalizations to the physician(s) identified by patients during the admissions process, and recommends modifying Policy H-225.946 to ensure that these notifications are made with appropriate patient consent. The Council further acknowledges that

future advances in the fields of HIT and telemedicine, along with more widespread use of ADT, will better enable hospitals to alert community physicians when one of their patients is hospitalized.

The Council believes that hospital-based and community physicians share accountability for the timely exchange of patient information and that communication must be bi-directional. Accordingly, the Council recommends adding two principles to Policy H-225.946. First, the Council recommends that contact information between these physicians be exchanged for routine and urgent situations, so that hospitalists can reach ambulatory providers when needed and vice versa. Second, the Council recommends that, to the extent possible, a patient's PCP or specialty physician relay information back to the inpatient medical team about the patient's medical history, medications, recent testing or other pertinent clinical data. The Council recommends additional minor modifications to further refine Policy H-225.946.

The Council's work on alternative payment models reinforces the notion that the lack of payment for physician consultative services may be undermining communications because physicians are not paid to take the time to talk with each other about the care of hospitalized patients. The Council is aware of alternative delivery models proposed by a variety of national medical specialty societies that incorporate interprofessional consultative services that are not currently compensated under the Medicare program. The Council acknowledges that the AMA has been engaged in advocacy efforts to enable physicians to be paid for these services, and recommends that the AMA continue to advocate for third party payment for interprofessional consultative services related to the care of hospitalized patients.

As directed by Policy H-225.946[3], the Council solicited feedback from the Federation about whether non-employed medical staff are being limited from admitting and treating their hospitalized patients. It is widely agreed that physicians who have admission and treatment privileges at a hospital should be allowed to treat their hospitalized patients to the full extent of their privileges. The Council encourages physicians who believe they are being prevented from doing so to communicate with their patients, the hospital-based physician(s) and the medical staff in an attempt to resolve these cases reasonably. Physicians should also refer to the hospital's medical staff bylaws, which often codify their right to exercise clinical privileges and prohibit infringement of this right. County and state medical associations are additional resources, as is the AMA Litigation Center, which provides physicians with legal expertise and assistance. The Council consulted with the AMA Litigation Center in the development of this report. To date, the Litigation Center has not received any requests seeking to challenge a hospital allegedly limiting the rights of non-employed medical staff members to admit and treat their patients.

The AMA is developing guidance to help medical staffs enact the principles outlined in Policy H-225.946. The Council recommends rescinding the third clause of Policy H-225.946 as this report accomplishes the requested study.

Finally, the Council believes that communication among physicians at the point of discharge is equally critical to well-coordinated, high-value care, and will present a report to the House of Delegates on discharge communications at the 2016 Interim Meeting.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 714-A-15 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between hospitals and primary care referring physicians, and to explore new mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-225.949, which encourages medical staffs to engage community physicians in medical staff and hospital activities around issues such as transitions of care. (Reaffirm HOD Policy)

3. That our AMA modify Policy H-225.946 by addition and deletion to read as follows:

   1. Our AMA ~~and the Organized Medical Staff Section (OMSS)~~ advocate that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; where the patient does not object, prompt notification of such actively treating physician(s) of the patient's hospitalization and the reason for inpatient admission or observation status ~~where such a relationship exists~~; to the extent possible, timely communication of the patient's medical history and relevant clinical information by the patient's primary care or specialty physician(s) to the hospital-based physician; notice to the patient that he/she may request admission and treatment by ~~such~~ actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges. 2. Our AMA ~~and the OMSS~~ advocate that a medical staff incorporate the above principles into medical staff bylaws, rules and regulations. ~~3. Our AMA will request that the AMA Litigation Center be alert for opportunities to challenge and the Advocacy Resource Center study and address the trend of hospitals' use of their employed hospitalists to limit the rights of their non-employed medical staff to admit and treat patients.~~ (Modify HOD Policy)

4. That our AMA continue to advocate that third party payers establish separate physician payments for interprofessional consultative services related to the care of hospitalized patients. (New HOD Policy)

Fiscal Note: Less than $500.

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