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Care Coordination for the Complex Medically Ill:
An Assessment of Primary Care and Hospitalist Alignment

Michael Radzienda, MD, SFHM
Foreword

Since the inception of the hospitalist model in the 1990s, both primary care physicians (PCPs) and hospitalists have worked to improve care coordination for medically complex patients. In 2001, a landmark study by Pantilat et al., described the perspectives of PCPs who utilized hospitalists. This was the first study that attempted to understand the barriers to effective, timely, patient-centered communication between hospitalists and PCPs. In the decade since, we have witnessed the evolution of new models of interdisciplinary care, like the patient-centered medical home. Despite the explosion of novel communication technologies, we continue to struggle with the same fundamental barriers to interprovider communication as described over a decade ago.

As we embark upon a new era in healthcare, where effective care coordination will be the key to success, we acknowledge the challenges that our interdisciplinary teams have in effectively communicating with one another. This research paper describes the results of a unique survey completed by nearly 4,000 PCPs and hospitalists. Our intent was to understand the barriers to timely, effective, closed-loop communication between hospitalists and PCPs who jointly care for the complex medically ill. We employed a Failure Modes and Effects Analysis (FMEA) methodology to prioritize areas for process improvement around PCP-hospitalist communication.

Future healthcare delivery models will require robust interprovider communication. We hope that this research will foster further alignment between PCPs and hospitalists who will be jointly accountable in coordinating the care of the complex medically ill. While health systems, payers, and physician organizations attempt to put the pieces of integrated care together, we must maintain and build on the relationships between the inpatient and outpatient providers who care for the sickest patients in our communities.

Our upcoming Expert Practice Series, Innovations in Care Coordination for the Complex Medically Ill, will build upon this research. The series will introduce best practices and innovative approaches from thought leaders who are tackling a fundamentally broken practice in today’s medicine: interprovider communication.

Sincerely,

Michael Radzienda, MD, SFHM
Executive Summary

In 2009, the seminal paper by Jenks et al, in *The New England Journal of Medicine*, found that 1 in 5 Medicare beneficiaries discharged from the hospital were rehospitalized within 30 days, at a cost of $17.4 billion in 2004. “Rehospitalization is a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care,” the authors wrote.

Many of the challenges and opportunities around discharge and other transitions in care are well-established. The need to find solutions is palpable, in no small part because, beginning in 2013, reimbursement penalties will take effect under the Patient Protection and Affordable Care Act for hospitals with higher than expected readmission rates for key conditions.

Of particular challenge is the population of patients known as the complex medically ill (CMI). The Society of Hospital Medicine (SHM) has adopted the U.S. Department of Health & Human Services definition, which describes this population as “patients with two or more concurrent chronic conditions which require ongoing medical attention and/or limit activities of daily living.” These patients consume a disproportionate amount of acute health care resources, composing up to 20% of emergency department (ED) visits, and also having a significantly higher likelihood of hospital admission and readmission. As such, CMI patients represent a challenge to both inpatient and outpatient providers charged with coordinating their care. These patients’ chronic conditions underscore other well-established challenges: hand-off communication, medication reconciliation, and patient compliance.

Despite these challenges—and according to new research from QuantiaMD and SHM—there is broad consensus among hospitalists and PCPs on the need to improve care coordination for CMI patients. More than 1,600 hospitalists and 2,300 PCPs participated in the research, offering perspectives on a wide range of care coordination best practices for CMI patients, and what future innovations hold the most promise for this vulnerable population.

Key findings from the research include:

- Hospitalists and PCPs are well-aligned on the importance of care coordination. Ninety-six percent of all respondents said improving communication between inpatient and outpatient providers who jointly care for CMI patients is important (16%) or extremely important (80%).

- Hospitalists and PCPs agree that at both admission and discharge, the most important element of the patient hand-off is accurate and timely communication of the patient’s current therapies, medications, and treatment.

- The top performance improvement opportunities related to care coordination between hospitalists and PCPs are:
  - Clear attribution of who to contact for questions upon discharge
  - Direct communication between PCP and hospitalist at discharge

- Despite tremendous advancements in technology over the past decade, telephone communication is still the most preferred form of communication between inpatient and outpatient providers, significantly outpacing second- and third-place options of electronic medical records (EMRs) and email.

- When asked to rank solution domains that would most improve care coordination for CMI patients, 50% of all respondents said “technology” (e.g., EMRs) was their number one choice, followed by “people” (30%) and “process” (20%).
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The survey results indicate strong resonance among both hospitalists and PCPs that making improvements in the communication process between hospitalists and PCPs is of high importance. Virtually all of the surveyed hospitalists (95%) and the surveyed PCPs (96%) identified this issue as extremely important or important (Fig. 1).

Fig. 1: How important do you think it is to improve communication between inpatient and outpatient providers who jointly care for CMI patients?

The survey asked both hospitalists and PCPs whether they should get more involved in treating CMI patients outside their own setting, i.e., PCPs in the inpatient setting and hospitalists in the outpatient setting (Fig. 2 and 3).

Fig. 2: PCPs should be more involved in inpatient care of CMI patients

Hospitalists, Weighted Average: 3.45  
PCPs, Weighted Average: 3.68
The survey results indicate:

- Both hospitalists and PCPs moderately agree that PCPs should be more involved in the inpatient care of CMI patients.
- Both hospitalists and PCPs are neutral as to whether hospitalists should be more involved in the outpatient care of CMI patients.

In open responses, many hospitalists acknowledged that the deep relationships between PCPs and their patients are critical to their own understanding—and ultimately the care—of CMI patients.

“Outpatient providers typically have more longstanding relationships with patients, and as such frequently have insight into patient conditions (treatment history/failure, patient compliance issues, etc.) that may not be readily apparent to the inpatient provider who is just meeting the patient,” said an internist in Palo Alto, CA.

 Others acknowledged that simply sharing data about the patient with the PCP isn’t enough, particularly for complex patients.

“There is more to understanding the complexities and nuances of patient care than what is dictated in an H&P or DC summary.” said a hospitalist in Eau Claire, WI.

In their open responses, PCPs indicated that poor communication between inpatient and outpatient providers creates delays in care, duplication of services, and threatens outcomes. Other PCPs said that it’s not reliable to assume the patient will be able to fully understand or communicate their status.

As one PCP practicing in Washington, D.C., said, “There is a level of understanding and management of both the patient and their illnesses that a specialist or PCP may not fully appreciate without having adequate communication between each other. Often, I do not get notes back from consultants about patients, or their notes are limited and don’t always document why they made changes. Patient care can become easily fractured, more complex and redundant, and thoroughly frustrating for all involved if we as providers don’t communicate. Furthermore, we pass up great opportunities to learn from each other if we don’t communicate better.”

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Not all of these patients can pick up the slack when they get out, and the discharge information is not always good enough. I hate that ‘moment of silence’ when I’m looking at the patient, and they’re looking at me, and we’re both wishing we knew what the plan was...

- Internist, Skokie, IL
The survey identified six elements of hand-off communication and asked the respondents to rate how essential (5 = extremely important, 1 = not at all important) they are to the care of CMI patients at admission and at discharge (Fig. 4 and 5).

### Improvement Opportunities

There was remarkable congruence between hospitalists and PCPs in these rankings. Except for one element, both hospitalists and PCPs rated the elements nearly the same and in the same sequence from high to low. The one area where there was a slight difference was “advanced care planning/advanced directive”, which hospitalists rated somewhat higher than PCPs did at both admission and discharge.

Fig. 4: How essential are the following six elements of hand-off communication to the care of CMI patients at admission?

<table>
<thead>
<tr>
<th>Element</th>
<th>Hospitalists</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current therapies, medications, treatments</td>
<td>4.48</td>
<td>4.45</td>
</tr>
<tr>
<td>History of present illness, PMH, most recent exam</td>
<td>4.21</td>
<td>4.22</td>
</tr>
<tr>
<td>Pending tests or recent testing results</td>
<td>4.18</td>
<td>4.22</td>
</tr>
<tr>
<td>Advanced care planning / advanced directive</td>
<td>4.17</td>
<td>3.97</td>
</tr>
<tr>
<td>Anticipated problems</td>
<td>4.05</td>
<td>4.08</td>
</tr>
<tr>
<td>Detailed account of recent hospitalization / or outpatient encounters</td>
<td>4.02</td>
<td>4.03</td>
</tr>
</tbody>
</table>

Fig. 5: How essential are the following six elements of hand-off communication to the care of CMI patients at discharge?

<table>
<thead>
<tr>
<th>Element</th>
<th>Hospitalists</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current therapies, medications, treatments</td>
<td>4.57</td>
<td>4.55</td>
</tr>
<tr>
<td>History of present illness, PMH, most recent exam</td>
<td>3.73</td>
<td>3.88</td>
</tr>
<tr>
<td>Pending tests or recent testing results</td>
<td>4.55</td>
<td>4.47</td>
</tr>
<tr>
<td>Advanced care planning / advanced directive</td>
<td>4.08</td>
<td>3.90</td>
</tr>
<tr>
<td>Anticipated problems</td>
<td>4.36</td>
<td>4.31</td>
</tr>
<tr>
<td>Detailed account of recent hospitalization / or outpatient encounters</td>
<td>4.28</td>
<td>4.30</td>
</tr>
</tbody>
</table>

**Source:** QuantiaResearch  [www.quantiamd.com](http://www.quantiamd.com)
Failure Modes and Effects Analysis

With the goal of trying to improve the communication between hospitalists and PCPs for CMI patients who have been hospitalized, the survey defined six elements of the hospitalist-PCP communication process:

1. Direct communication at admission
2. Daily notification to PCP on patient status
3. Direct communication with PCP at discharge
4. Generation of discharge summary within 24 hours of discharge
5. Clear attribution of who to contact for questions upon discharge
6. Direct contact with PCP for major changes in patient status

Hospitalists and PCPs survey respondents were asked to rate each of these six elements on a 1 to 5 scale along the following three dimensions:

- How important is it?

- How reliably does it occur?

- How difficult is it to execute?

These scores were incorporated into a Failure Modes and Effects Analysis, a systematic method of evaluating a process. Failure Modes and Effects Analysis was developed outside of the healthcare industry, but it is increasingly used to improve healthcare quality through prioritizing process improvement activities.

Using the survey responses, three risk-priority scores were computed for each element in the hospitalist-PCP communication process: one for hospitalists, one for PCPs, and one for the total group that include both hospitalists and PCPs. The resulting scores were then used to rank the six elements, with 1 the highest priority and 6 the lowest priority.
The results of the Failure Modes and Effects Analysis are summarized below. *(Fig. 6.)*

**Fig. 6: Communication Domain - Failure Modes and Effects Analysis Prioritization*  
(1 = highest rank score)**

<table>
<thead>
<tr>
<th>Events / Process</th>
<th>Hospitalist Rank</th>
<th>PCP Rank</th>
<th>Group Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear attribution of who to contact for questions upon discharge</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Direct contact with PCP for major changes in patient status</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Direct communication with PCP at discharge</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Generation of discharge summary within 24 hours of discharge</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Direct communication at admission</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Daily notification to PCP on patient status</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

*Prioritization Matrix Score Formulas = (Importance of event x Ease of doing)/Reliability of current process  
N = 1642 Hospitalists, N = 2276 PCPs  
Source: QuantiaResearch  www.quantiamd.com

The results can be interpreted as follows:

- **Green**: Two elements in the hospitalist-PCP communication process (those in green for all three groups) should be considered a high priority for improvement initiatives:
  - Clear attribution of who to contact for questions upon discharge
  - Direct communication with PCP at discharge

- **Yellow**: Two elements in the hospitalist-PCP communication process (those in a mix of green and yellow) should be considered intermediate priorities for improvement initiatives:
  - Direct contact with PCP for major changes in patient status
  - Generation of discharge summary within 24 hours of discharge

- **Red**: Two elements in the hospitalist-PCP communication process (those in red for all three groups) should be considered lower priorities for improvement efforts:
  - Direct communication at admission
  - Daily notification to PCP on patient status

This prioritization can help inform process improvement efforts around hospitalist-PCP communication for CMI patients.
As documented in the following table, there are some interesting similarities and differences between hospitalist and PCP ratings of the importance, reliability, and difficulty of the six elements of the hospitalist-PCP communication process. The table shows the average hospitalist and PCP ratings for each of the six elements with 5= extremely important, always reliable, extremely easy and 1 = not at all important, never reliable, extremely difficult (Fig. 7).

<table>
<thead>
<tr>
<th>Element Description</th>
<th>Hospitalists</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct communication at admission</td>
<td>3.86</td>
<td>4.05</td>
</tr>
<tr>
<td>Daily notification to PCP on patient status</td>
<td>3.12</td>
<td>3.01</td>
</tr>
<tr>
<td>Clear attribution of who to contact for questions upon discharge</td>
<td>2.78</td>
<td>3.12</td>
</tr>
<tr>
<td>Direct contact with PCP for major changes in patient status</td>
<td>4.05</td>
<td>4.22</td>
</tr>
<tr>
<td>Generation/receipt of discharge summary within 24 hours of discharge</td>
<td>4.48</td>
<td>4.39</td>
</tr>
<tr>
<td>Direct contact with PCP at discharge</td>
<td>4.41</td>
<td>4.25</td>
</tr>
</tbody>
</table>

Note: N=1642 Hospitalists, N=2276 PCPs
Source: QuantiaResearch  www.quantiamd.com
The results can be interpreted as follows:

- **Regarding importance:** there is alignment among hospitalists and PCPs on four of the six elements of the communication process and relatively close alignment on a fifth element (direct communication at admission). Hospitalists rated “daily notification to PCP on patient status,” below average (2.57) while PCPs rated it above average (3.27). *(Note: 1=not at all important, 5=extremely important)*

- **Regarding reliability:** there was congruence of hospitalists and PCPs on two of the elements of communication; “direct communication at admission” was rated with average reliability (3.12 and 3.01) and “daily notification to PCP on patient status” was rated at poor reliability (2.17 and 2.34). However, for the other four elements there were differences in the average ratings of hospitalists and PCPs of .63 to 1.10. Hospitalists believe these processes are more reliable than do PCPs. *(Note: 1=never occurs reliably, 5=always occurs reliably)*

- **Regarding difficulty,** hospitalists and PCPs rated “direct communication with PCP at discharge” (3.21 and 3.08) and “direct contact with PCP for major changes in patient status” (3.13 and 3.00). However, hospitalists rated two elements more difficult – “direct communication at admission” (2.78 vs. 3.12) and “daily notification to PCP on patient status” (2.12 vs. 2.69). PCPs rated two elements more difficult – “generation of discharge summary within 24 hours of discharge” (3.93 vs. 3.15) and “clear attribution of who to contact for questions upon discharge” (3.71 vs. 3.13). *(Note: 1=extremely difficult, 5=extremely easy)*

This Failure Modes and Effects Analysis ranking provides a context for setting priorities. The intergroup differences in rankings may be used to facilitate a meaningful discussion between hospitalists and PCPs.

“**I've seen some examples of great communication and not-so great communication in my career, and I can tell you, it greatly impacts quality of care and my ability to keep these people out of the hospital in the future.**”

- Internist, Glendale, AZ

“**With the current state of medical technology and pharmacology, the care of these complex patients is like a house of cards: when one card starts to fall, so will the others, without very delicate coordination. [Care coordination] can only happen with excellent communication between physicians.**”

- Hospitalist, Dallas, TX
Solutions

The survey asked the respondents to rank (1, 2, or 3) their preferred communication media, and the results showed remarkable alignment (Fig. 8).

**Fig. 8: Rank #1 your preferred communication media**

<table>
<thead>
<tr>
<th>Media</th>
<th>Hospitalists</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>61%</td>
<td>58%</td>
</tr>
<tr>
<td>Email</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>EMR &quot;in basket&quot;</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>Electronic fax (i.e., digital)</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Traditional fax (i.e., analog)</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Text message / SMS</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Mail</td>
<td>1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Social networking application</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

N = 1634 Hospitalists, N= 2267 PCPs.
Source: QuantiaResearch  www.quantiamd.com

Telephone was the most preferred (61% and 58%), with email (12% and 11%) and electronic medical records (11% and 14%) fairly close as second preferences.

Additionally, 82% of hospitalists and 87% of PCPs said these preferences do not change based on point of care (e.g., admission, status change, and discharge).

The survey asked the respondents to rank (1, 2, or 3) what is needed to improve care coordination between the inpatient and outpatient settings for CMI patients (Fig. 9).

**Fig. 9: Rank #1 what is needed to improve care coordination**

<table>
<thead>
<tr>
<th>Category</th>
<th>Hospitalists</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology (e.g., EMRs, HIE, overlays, applications, etc.)</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>Process (e.g., algorithms, post-discharge call centers, care paths, etc.)</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>People (e.g., employment of non-MD coordination support, training, etc.)</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

N = 1636 Hospitalists, N= 2305 PCPs.
Source: QuantiaResearch  www.quantiamd.com
More hospitalists and PCPs (53% and 49%) felt technology solutions (such as electronic medical records, health information exchanges, overlays, mobile applications, etc.) would improve care coordination than people-based solutions (30% and 30%) or process-based solutions (18% and 21%).

Many respondents cited efficiency and reliability as their reason for choosing technology. One respondent described how an effective EMR system would improve care coordination:

“I think that the most reliable and efficient way to communicate between in-patient and out-patient settings is through a common electronic medical record which is accessible in both settings. When a hospitalist is admitting a patient, he should have immediate access to the patient’s outpatient electronic medical record; likewise, the patients’ outpatient provider should receive immediate notification electronically when one of his or her patients has been admitted, and have the ability to follow the daily progress of that patient remotely from his office, with access to daily notes, labs, consults, etc.,” said a hospitalist in Middlefield, CT.

But, there were also some caveats around technology-based solutions, namely interoperability issues, limitations on communication, and high barriers to adoption.

“Technology would make communication easiest if utilized effectively, but people have to use it!” said a family physician in Marietta, GA.

And while sentiment varied on what would most improve care coordination, many physicians also acknowledged that the best care coordination practices are multi-faceted, combining all three aspects: technology, people, and process.

“Although technology advancement can make the communication and coordination more efficient, the effort still has to be put forth. Routines are critical and should be built into the daily care of patients to coordinate CMI patients from hospitalist, PCP, and social worker, as well as post-discharge contact (at least one call) from either hospitalist coordinator, physician extender, or from the hospitalist physician directly whenever possible,” said an internist in Danville, IN.

“Although technology advancement can make the communication and coordination more efficient, the effort still has to be put forth. Routines are critical and should be built into the daily care of patients to coordinate CMI patients from hospitalist, PCP, and social worker, as well as post-discharge contact (at least one call) from either hospitalist coordinator, physician extender, or from the hospitalist physician directly whenever possible.”

- Internist, Danville, IN
In summary, hospitalists and primary care physicians are well-aligned on the importance of care coordination for CMI patients, and there are clear opportunities to improve communication methods between these two types of providers. These opportunities include:

- Clear communication between hospitalists and PCPs at discharge and admission of CMI patients’ current therapies, medications, and treatments
- Ensuring that there is clear attribution of who to contact for questions at the time of discharge
- Facilitating direct communication with the PCP at discharge

While the majority of respondents agree that technology solutions hold the most promise for improving care coordination, for now, the telephone is still the most widely used form of communication between these two provider groups.

Many healthcare organizations are already working on a range of interventions designed to improve outcomes and reduce readmissions for CMI patients. A new Expert Practice Series in the Reducing Readmissions special interest group from SHM and QuantiaMD, *Innovations in Care Coordination for the Complex Medically Ill*, specifically highlights challenges and opportunities related to such interventions. Topics range from patient-centered medical homes to tele-health to post-discharge clinics, and feature actual case studies of existing care coordination efforts between hospitalists and PCPs.

The full list of topics and faculty for SHM and QuantiaMD’s expert practice series, *Innovations in Care Coordination for the Complex Medically Ill*, includes:

- **Overview of Care Coordination for the Complex Medically Ill**—Michael Radzienda, MD, SFHM, Chief Medical Officer, Sound Physicians
- **Post-Discharge Care and Clinic Innovations**—Lauren Doctoroff, MD, Hospitalist, Beth Israel Deaconess Medical Center, Medical Director, Health Care Associates Post Discharge Clinic
- **Maximizing Continuity of Care: An Ideal Patient-Centric Model**—Renu Goyal, MD, FHM, Chair, Department of Hospital Medicine, Reliant Medical Group at Saint Vincent Hospital, Assistant Professor of Medicine, University of Massachusetts Medical School
- **Community Care Coordination for the Complex Medically Ill: Critical Services**—Valerie Parker Callahan, Planning and Development Director, Greater Lynn Senior Services, Lynn, MA
- **A Hospitalist/PCP Coordination Intervention**—Elizabeth Gundersen, MD, FHM, Assistant Medical Director, Hospice of Palm Beach County, and Ronald Adler, MD, Director of Quality Improvement for Primary Care, UMass Memorial Healthcare
- **Hospitalist Integration with Patient-Centered Medical Homes**—John Bulger, DO, FACP, CACOI, Chief Quality Officer, Geisinger Health System
- **PCP Integration with Patient-Centered Medical Homes**—Frederick Bloom, MD, Director, Quality Care and Practice Excellence in Family Medicine, Geisinger Health System
- **Telehealth in the Management of the Complex Medically Ill**—Lynn C. Jones, FACHE, President, Christiana Care Visiting Nurse Association, Chairman of the Board, Visiting Nurse Associations of America; Cheryl Ann Alexander, RN, BC, Lead Cardiac Clinician, Christiana Care Visiting Nurse Association
- **Leveraging Technology to Enhance CMI Care Coordination**—Michael Radzienda, MD, SFHM, Chief Medical Officer, Sound Physicians, and Winthrop F. Whitcomb, MD, MHM, Hospitalist, Department of Medicine, Baystate Medical Practices
Demographics

Care Coordination for the Complex Medically Ill: An Assessment of Primary Care and Hospitalist Alignment is a joint study by SHM and QuantiaMD. The survey was fielded between October 7, 2011 and November 23, 2011 on QuantiaMD, the leading mobile and online physician community. Hospitalists and primary care physicians were invited via email to participate in the study. Among our 3,974 respondents, 42% were hospitalists, and 58% were primary care physicians.

A plurality of respondents described their practices as suburban (39%), followed by urban (28%), rural (13%) and inner city (8%). Forty-seven percent of respondents were from small practices with 1-9 physicians, while 31% of respondents were from practices with 10-49 physicians. Lastly, respondents fell across the spectrum when it came to years in practice, with the plurality (39%) representing physicians with 0-10 years of experience (Fig. 10).

Fig. 10: Demographics of clinician respondents

N = 3932
Source: QuantiaResearch www.quantiamd.com
Acknowledgements

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SHM’s participation in this survey is part of a broader study of care coordination for CMI patients being conducted with the financial support of Janssen Pharmaceuticals, Inc.

References


