Areas of knowledge and proficiency for inpatient medicine

1. **Soarian training and access** – with certification of competency.
2. **Remote access to EHR** when applicable – signing orders or completing charts remotely or taking call or supervising other providers when not on-site.
3. **CDI queries** – what they are, how and when they need to be addressed. Meeting with CDI staff as part of training.
4. **Observation and admission criteria** and guidelines as well as 2MR rule. Meeting with Care Management staff as part of training.
5. **Core measures**. Review of all current core measures, how they are to be addressed, and awareness of Peer Review process when items not addressed as per guidelines.
6. **Multidisciplinary rounds** – what they are and need to be engaged promptly with MDR discussions and recommendations with respect to your patients
7. **Secure text messaging (STM)** with Tiger Connect. Needed for hospital work to facilitate both clinical care and care coordination. Detailed review of all current multiple facets of use (HIM, PCP, Case management, nursing, contacting consultants, ER, radiology, etc.). Review of need for clear responses, inability to place orders with STM, message forwarding feature, and current status as first choice for communicating with all hospital personnel who use it.
8. **HCAPS** – review of HCAPS program and how scoring is done as well as where and how to view scores.
9. **Communication with PCP** at admission and discharge and at changes in condition. Either phone call or STM anticipated in most/all patients except very low acuity. Exception – patients who have no PCP.
10. **MOLST** forms, Advance Directives, Hospice, Palliative Care services – familiarity with these services as well as where and how to document them in the medial record
11. Need for **daily meetings with Case Management** and preplanning discharges including having certain discharge summaries completed day before discharge so that discharge planning can be completed on time.
12. **Quality Review program**. Description of CH combined program for Medicine and Family Medicine.
13. **LOS data** – what date is tracked and importance of managing LOS with anticipation that results will be at “Top Decile” range on reports. Where and how to find these reports on the website and need to review those data periodically.
14. **Department of Medicine website** and information available there including LOS toolkit with recommendations on ways to make hospital stays more efficient.
15. **Guidelines and expectations of hospitalists**. Document available on website. Review and adoption of these items.
16. **Department policies**, rules, regulations, and best practices. Also available on website.
17. **Coding and documentation**. To include meetings with pertinent hospital staff about this.

18. **Targeted disease programs** – including sepsis bundle, code stroke, etc. What they are and the details of these programs.
19. **Rapid response and MEWS program** – what they are and how they work. MEWS currently available only at KMH site. Responsibilities of hospitalist to address all clinically evolving issues in their own patients.
20. **Verbal orders**. Review of important issues related to verbal orders, including the fact that they are discouraged and CPOE is the standard, that they not to be used when on site and CH computers are available, that they need to be signed within 24-48 hours, and where to find them in Soarian and EDM. Remote access to EHR should be used in preference to verbal orders whenever feasible when orders need to be given when not having access to dedicated CH computer.
21. **Medhost program** in ER and how it is not fully integrated with Soarian and which information may be found in which system and how to facilitate navigating both systems.
22. **HEALTHeLink and Surescripts**. Need access and knowledge comfortably to use both systems to obtain data, including medicine reconciliation facilitation by searching for prescription fill history whenever appropriate.
23. Review of formalized handoff process group will be using for both short term signout and "off service" transition to new provider or provider team.
24. **Timeliness** – all calls, queries, requests etc. need to be addressed timely in all situations.
25. **Morning rounds** – rounds should begin routinely in the morning, during or before MDR's. Patients admitted overnight should be seen early to facilitate appropriate reevaluation, any changes in preliminary diagnostic and therapeutic plans, and facilitating care coordination with early planning when services and facilities are most available.
26. **New patients** – observation or admission – coming into the hospital during day or evening should be evaluated same day both for making the appropriate clinical evaluation but also to facilitate coordination of testing, treatment, and post-hospital planning.