NEW PERSPECTIVES

Looking in from the Outside

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As we see the continued development of the hospitalist movement in general medicine, more and more outpatient physicians like myself have chosen to let inpatient medicine be done by inpatient physicians. I generally visit my patients in the hospital if I know that they have been admitted locally but do not really get involved in the care to any great degree. Often, they are admitted out of town. Still, at some point, they are considered fit to leave and are returned to my care. As the outpatient gatekeeper, I find the system generally works well, and having inpatient and outpatient physicians as separate entities has many advantages. Still there are some issues that continue to hinder what otherwise could be a very efficient and streamlined system.

I work in a relatively closed system (VA Hospital system) but still may not find out until later that my patient has been admitted. Sometimes I find out because I receive reports about tests and their results while my patient is hospitalized, but most of the time it is a surprise. There does not seem to be any real coherent system to notify the primary care outpatient physician that his/her patient has been admitted. Even if the patient is admitted to my home hospital, I am hardly ever notified. It is very rare that I am notified if my patient is admitted to an outside facility. There are obvious advantages to being notified of my patient's admission, such as making sure the hospitalist has accurate records and to fill in any gaps or concerns that he/she might have. It also helps to facilitate the coordination of care long before discharge.

Another big issue that arises for me is that medications are often changed during the admission. Some medications are stopped altogether for one reason or another, and others are added. Patients return to me confused about what they should now be taking. Should they continue the inpatient medication or restart ones they were on before? Hospitalists who use specific discharge planning with medications, especially when it is done by a pharmacist, tend to be the best. It is also helpful for the discharge instructions to include not just a list of medications but also changes (i.e. "this one was discontinued" or "these two were added"). It is not always clear from the discharge summary why certain changes were made, and including this in the medication summary would also be very helpful.

Often I am asked where to schedule one of my patients because the patient was told that he/she needs to see me one week (or other time frame) after hospitalization. These intervals for the most part seem arbitrary. Even if a lab needs to be rechecked or followed in a week, generally the patient does not need to be seen. It would be helpful for me to review the discharge information and decide for myself when to make the appointment for the patient. If the patient needs to have a specific issue followed up but the discharge summary is not done, the patient may come to me not knowing exactly what the issue is. This can result in a wasted visit for both the patient and myself.

Getting records from the hospitalization is often an additional problem. When the discharge summary is delayed or the patient arrives in clinic without any information about the hospitalization, I spend time piecing together what happened or chasing outside records. This also results in a time consuming and often non-productive visit, especially if I did not know that the patient was hospitalized in the first place.

I also find I am almost never personally contacted by the hospitalist at the time of discharge. Occasionally, I may get an e-mail, but that is rare. I realize time constraints probably play a big role in this lack of communication, but being able to discuss the case as it is wrapped up would be very helpful. This would also be more of a handoff, which is a "hot-button issue" for hospitalists in general and would lead to much better coordination of care.

Unfortunately, my patients deal with multiple health care facilities with differing policies and procedures. Nonetheless, the issues I have listed here tend to be recurring themes. As practitioners of general medicine and primary care, we need to continue to evaluate and improve these issues, especially given the trend toward fragmentation of care between inpatient and outpatient medicine. There are many advantages to this division; we just need to continue working on making it more efficient and streamlined. *SGIM*