From Intensive to Primary Care: Bridging the Gap for Better Medicine

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KEY WORDS
coordinated care, medical home, health care reform, adherence, humanities

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doi:10.1542/hpeds.2011-1024

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HOSPITAL PEDIATRICS (ISSN Numbers: Print, 0031 - 4005; Online, 1098 - 4275).
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FINANCIAL DISCLOSURE: The author has indicated she has no financial relationships relevant to this article to disclose.

Claire* was a female patient in her early twenties with long-standing, poorly controlled diabetes and a rare inherited disorder who had just been transferred to our general pediatric inpatient service. Initially, Claire was admitted to the floor of this pediatric hospital after presentation to the emergency department with a skin abscess that required intravenous antibiotic therapy after incision and drainage. Unfortunately, due to delay in presentation and her underlying medical vulnerabilities, the infection evolved into systemic inflammatory response syndrome, and Claire required admission to the ICU. After a week of noninvasive respiratory support, she was being transferred back to the general medical unit. Her acute clinical course had resolved, and now our team, composed of a hospitalist, consulting endocrinologist, residents, and medical students, was expected to send her home.

At the time of transfer from the ICU, her discharge plan was all but signed. She would complete an oral antibiotic regimen and, at least according to the paperwork, follow-up with her endocrinologist, neurologist, and primary care physicians after discharge. Even before returning to the floor, her hospital discharge summary was written, medications pre-prescribed, and a list of follow-up appointments created. After all, her acute illness was resolved; she could go home.

By most accounts, this patient was receiving high-tech, organized, and therefore sophisticated care. But after evaluating Claire as a team, it became clear that a few pieces of paper with instructions before discharge home would not suffice. Claire was a person with great humor and spirit, her life had been consumed by illness and personal struggle. Initially raised by an older relative because her parents were either deceased or uninvolved, she became a victim of abuse and subsequently spent her adolescence in foster care. Although she had finished high school and was an avid artist, she became pregnant as a teenager and was now a single mother and unemployed. Over the past few years Claire had been admitted at least a dozen times for diabetic complications and had spent as much time in the hospital as at home.

Claire's frequent readmissions were, in part, resulting from open nonadherence to her pharmacologic regimen and missed outpatient appointments. Few of her caregivers, if any, knew why, and if someone did know, the reasons for her limitations in self-care had not been communicated to her other providers. Although Claire did have some social support from her boyfriend, his presence in her life—in the

*The patient's name has been changed, and potentially identifying information has been omitted or made less specific to protect the patient's identity.
patient’s words—was mediated by his desire to have another child with her. Already ambivalent about her role as a parent, she did not use contraception regularly, nor was she informed of her contraceptive options. Somehow irregularly, nor was she informed of her parent, she did not use contraception.

During a hectic, demanding day on an inpatient floor, the broader goals of care can be forgotten. Perspective about a patient’s overall health can be lost among the details of last-minute orders, discharge documentation, and follow-up planning. While juggling the complex care of a dozen patients, the bottom line of maximizing care without added cost, minimizing length of stay without compromising outcome, documenting "everything," and ensuring a safe, justified discharge is ever-present. Any “left-over” health maintenance not addressed during admission for an acute illness is left to follow-up by the primary care physician. After all, the hospital is a place for acute illness, not preventive care.

But what happens when patients do not follow the rules?

Claire’s initial complaint likely could have been prevented by good outpatient glycemic control and early antibiotic therapy. Due to poor adherence, delay in presentation, and an underlying metabolic illness, she required costly inpatient care. Now, the likelihood of her making the next round of outpatient appointments was as slim as ever; this was especially true for her yearly preventative care visit.

Fortunately, at the suggestion of the attending physician and consulting endocrinologist, the decision was made to have an open, in-depth discussion with the patient regarding the importance of adherence to care, medical risk, and social consequences of an unplanned pregnancy. Claire agreed to start contraception before discharge and contracted verbally to follow-up care. A pregnancy test was ordered on the floor, and the contraception was included in her discharge prescriptions in-hand. A social worker was consulted and provided tangible resources that might assist Claire, including follow-up telephone calls to make sure she followed through on appointments. The outpatient care providers were also made aware of and agreed to the plan to maximize its effectiveness.

Although Claire’s hospital course was dominated medically by intensive care, perhaps one of the most important interventions during her stay was low-tech and preventative: birth control. Although unrelated to her presentation, preventing an unplanned pregnancy that would not only be a health risk to Claire but also a significant personal and societal expense was invaluable. Admittedly, this conversation required at least 1 hour of time, and the pregnancy test performed in the hospital was likely more expensive than the equivalent laboratory test performed as an outpatient. However, the patient’s length of stay was not prolonged, and both an unplanned, high-risk pregnancy and a repeat admission due to poor follow-up were expensive outcomes worth preventing.

As an inpatient provider, it can often be easy, and typically appropriate, to forgo a “maintenance” diagnostic test or social intervention conducted in-house for the primary care provider who can follow-up long-term with less expense and typically more expertise. Much of the recent health care reform has rightfully emphasized cost-effective preventive outpatient care while working to decrease costly and potentially frivolous inpatient workups.

However, this shift in care delivery does not relieve the inpatient provider of the responsibility to evaluate a patient as a complete person, including assessment of social risk factors that may place the care plan in jeopardy. The only opportunity for preventive care may be in the hospital during an acute illness. This concept is well known in the field of global health in which access to care can be consistently poor. A chief intervention for HIV/sexually transmitted disease treatment in many settings is to test and initiate treatment of women hospitalized for obstetrical delivery, which may be the only time women seek or gain access to medical attention throughout their lives.

As with most challenges in medicine, a thorough understanding of the patient’s social life, education level, and medical home is crucial, both for the patient and for society as a whole. In the era of increasingly specialized and often-fractionated care, coordination of this care between providers is paramount. With broader recognition of this principle, more attention and appreciation are being paid to the medical home, understood not only to improve patient satisfaction and adherence but likely decrease cost. Although the medical home has been primarily developed as an outpatient venture, some hospitals have created services that provide coordinated care to patients with complex or chronic
medical problems. Such departments facilitate cooperation between providers and enable continuity of care. These efforts should not only be applauded and supported but also expanded. Patients should not have to be diagnosed with a chronic or complex illness to be provided with reliable provider-to-provider communication, effective documentation, assistance with treatment adherence, and efforts to improve medical literacy.

Specifically, the thoroughness of care provided to Claire should not have been left to the particular attentiveness and compassionate care of the inpatient providers in this case. On a busier day, the patient may have been discharged with paper in hand without further discussion. Not only are systemic, administrative changes necessary to facilitate communication between all providers, but each physician’s approach to an individual patient must maintain a commitment to these standards regardless of a patient’s care complexity or the physician’s specialty (ie, primary care, hospitalist, or specialist). More should be done to educate both inpatient and outpatient providers on how to perform these tasks in addition to breaking down the administrative and technological barriers to performing them. Just as undergraduate medical education has recently undergone a revolution in teaching trainees how to approach performing a history and a physical, graduate medical education must accept that training in professional communication and care coordination is equally important to creating a high-quality health system that is not only comprehensive but safe. Ancillary staff, including case managers and social workers, can provide excellent assistance in execution of these goals, but they are not a substitute for physicians performing a clinical assessment that considers the whole patient.

Ultimately, a physician should never hesitate from intervening on behalf of an individual patient because the physician is having a busy day, feels the task does not reflect his or her job title, or is meeting a payment incentive. Many of these pressures can drive physician action, subconsciously or not, particularly in the hospital setting that has presumed boundaries of care coordination. Administrative hurdles should never supersede clinical judgment and common sense to provide effective, individualized care, especially for disadvantaged patients. For it is the challenge of providing effective care for the whole patient, such as with Claire, regardless of whether that patient is adherent, that requires each of us as physicians to remain inquisitive, flexible, and thorough each and every day, both individually and as a team.