Coordinating the Medical Home with Hospitalist Care

A commentary written by Jerrold Eichner, MD, FAAP, and W Carl Cooley, MD, FAAP, for Hospital Pediatrics discusses the expectations and benefits of coordinating patient care between a medical home and hospitalist. A patient's medical home provider delivers and/or coordinates all primary, preventive, acute, and chronic care. The article indicates that hospitalization can be a stressful time for patients and their families and that information sharing between the hospitalist and medical home at hospital admission, during hospitalization and at discharge can ease the transition across care settings and prevent adverse patient effects. The following is a summary of the commentary, "Coordinating the Medical Home with Hospitalist Care."

The Roles of the Hospitalist and the Medical Home With Each Other and Families

- When a patient is admitted to the hospital, the hospitalist should receive the following information from the patient's medical home: the rationale for admission, the working diagnosis and chronic conditions, relevant medical history, applicable laboratory and radiology test results, and the patient's and family's reaction to hospitalization.

- During hospitalization, the hospitalist should communicate the following information to the patient's medical home: the patient's progress, as well as significant events, surgeries and other procedures occurring during the hospital stay.

- Care coordination and effective communication between the medical home and hospitalist is crucial for children with complex medical conditions. A hospital visit from the medical home physician to a patient with special health care needs may be necessary in order to endorse the care provided while in the hospital, suggest possible care revisions, fill in gaps in the patient's history, clarify patient or family preferences for care, and become familiar with the patient's condition in the hospital in order to benefit outpatient care.

- Before a patient is discharged from the hospital, the hospitalist, medical home and family should agree on the conditions and timeliness of discharge. If the family is unprepared to handle the patient's care needs at discharge or the medical home is unable to provide timely follow-up with the patient, then discharge should be delayed to protect the patient's safety.

- The hospitalist should notify the medical home about a patient's discharge via telephone and then fax, e-mail or mail discharge instructions to the medical home.

- Hospitalists should provide the following information to the medical home upon discharge and before the first follow-up visit: the diagnosis at discharge, required medications, laboratory and radiology test results, pending test results and the timing for follow-up appointments. In addition, the hospitalist should give families a written plan to follow that includes instructions if the patient's condition changes and who to contact with problems or questions before the follow-up visit with the medical home.

Benefits of Hospitalist and Medical Home Communication

- Effective communication between the hospitalist, medical home and patient's family ensures that the patient receives the best comprehensive medical care possible. Poor communication at admission and discharge can have a negative impact on the patient.

- Successful communication at discharge can prevent hospital readmission and unfavorable events from medical errors especially medication errors, failure to have follow-up diagnostic tests performed, and inadequate adherence to the treatment plan.

- A medical home can create cost savings by helping to avoid hospital readmission, duplication of laboratory and radiology tests, and medical errors.
Transitions of Care

The commentary also highlights the principles for effective care transitions from the 2009 “Transitions of Care Consensus Policy Statement,” including:

- clear and direct communication of treatment and follow-up plans;
- timely feedback and communication of information;
- involvement of the patient and family member whenever appropriate;
- showing respect for the medical home – also known as the hub of coordination care;
- the ability of patients and families to identify their medical home or coordinating physician; and
- clarity for patients and families at all times during transitions about who is responsible for care at a given time and that person's contact information.

In addition, the commentary lists standards that were identified by the Transitions of Care Consensus Conference attendees from the transitions of care principles. Some of these standards include identifying the coordinating care physician, involving the patient and family in the transition care plan, and ensuring there is a communication infrastructure.


Note: Summary based on article in Hospital Pediatrics. Copyright 2012 by the American Academy of Pediatrics