Communication Between the Primary Care Physician and the Hospitalist at the Time of Patient Admission

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ABSTRACT

- **Objective:** To assess the response of primary care physicians (PCPs) to a faxed request for patient information from the admitting hospitalist at the time of a patient's hospital admission.

- **Methods:** On the day of admission, the attending hospitalist faxed a form to the PCP requesting 7 items of standard medical record information that are important for optimal patient care. Receipt was confirmed by telephone follow-up. The total number of responses and timing of responses were recorded.

- **Results:** Of the 77 faxes that were sent, 41 (53%), were completed. 82% of responses were received within the first 24 hours. Five (15%) of the responses were 100% complete. Medication list was the most frequently completed item and code status was the least frequently completed. Two PCPs made phone contact, no PCP used email contact.

- **Conclusion:** Communication between the PCP and the hospitalist at the time of admission is suboptimal. Fax, telephone, and email methods are underutilized.

Over the past 20 years the practice of medicine has become fragmented. Fewer physicians care for their patients in both the outpatient and inpatient settings [1]. Primary care physicians (PCPs) care for patients in the community, while hospitalists care for these patients while they are in the hospital [1–3].

Multiple studies have shown communication deficits at the time of transitions of care between outpatient and inpatient settings [4–7]. A Society of Hospital Medicine/Society of General Internal Medicine task force found that communication between hospital physicians and PCPs occurs in only 3% to 20% of cases [8]. Most studies have focused on communication at the time of hospital discharge [9–11]. Studies that have focused on communication at the time of admission have reported a high incidence of medication errors [12] and low documentation of code discussions [13].

Medical societies, regulatory agencies, insurance companies, and others are currently involved in making policies to improve patient care at the times of transition. In 2007, the American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society of Academic Emergency Medicine convened for the Transitions of Care consensus conference and developed consensus standards to address quality gaps in the transitions between inpatient and outpatient settings [7]. They established 9 principles: accountability, communication, timely interchange of information, involvement of the patient and family member, a hub of coordination of care, a coordinating clinician, patient knowledge of who is responsible for their care, national standards, and standardized metrics [7]. Among their specific proposals was that communication and information exchange between the medical home and receiving providers should occur in a timely manner, include a core standardized dataset, and include bidirectional functionality with opportunity for clarification and feedback.

In the current study, we assessed primary care physicians’ responses to a faxed request form informing them of their patient’s hospital admission, providing the hospitalist’s name and contact information, and requesting pertinent patient medical information.

From the Penn State Milton S. Hershey Medical Center, Hershey, PA.
COMMUNICATION AT ADMISSION

METHODS
Patients and Setting
The study cohort was patients admitted to the internal medicine service of a 500-bed tertiary care academic medical center in central Pennsylvania. The majority of patients admitted to the service are admitted through the emergency department. Patients were included if their primary care physician was not connected to our internal electronic medical record (EMR) system. Access to records of patients whose physicians are not connected to our EMR system has traditionally been through phone and fax communication initiated by the hospital physician to the primary care office. Patients whose care depended upon critical information requiring urgent phone contact with the primary care physician were excluded from this study.

Data Request Form
We developed a standardized information request form for faxing to PCPs (Figure). The form requested 7 items: medicine list, problem list, allergy list, vaccination status, code status, date of last visit, and response to any patient-specific inquiry (if added) from the hospitalist. The PCP was also invited to add any information he thought would be beneficial to their patient’s hospital care. The form included the attending hospitalist’s name, email, pager number, telephone, and fax number. Content of the form was based on Joint Commission standards [14] and the data elements recommended for inclusion in a transition record per the Transitions of Care consensus conference.

Process
Between July 2009 and March 2010 (Monday through Thursday, excluding holidays) the hospitalist attending completed the request form at the time of a patient’s hospital admission. The PCP was identified by the patient’s information face sheet or by the patients themselves. Forms were faxed to the PCP within 24 hours of the patient’s admission. Immediately after sending the fax, the hospitalist’s administrative assistant called the PCP’s office to request acknowledgment of receipt.

Analysis
The total number of responses, responses by category, and timing of responses were tabulated and percentages calculated. The open-ended question regarding any additional pertinent information the PCP thought would be beneficial to add was not quantified.

RESULTS
Average age of the patients was 72 years (range, 50–89 years). Seventy-seven faxes were sent to PCPs. Forty-one (53%) PCPs responded. Seven responses were excluded, as the PCPs indicated that the patient was no longer under their care. Of the 34 included responses, 18 (53%) replied the same day, 10 (29%) replied within 1 day, and 6 (18%) replied in 2 days or later. Two PCPs called the hospitalist by phone to discuss the patient’s care plan. There were no email contacts.

Only 5 (15%) replies were 100% complete (Table). Medication and problem lists were more often reported

Figure. Information request form faxed to primary care physician.
at 91% and 88%, respectively. Code status was the least documented item at 21%. Replies were sent mostly as copies of medical records, which included handwritten, typed, and computer-generated pages (See Appendix for examples of responses). Number of pages faxed by PCPs varied from 2 pages to 25 pages.

DISCUSSION

In our study, PCPs responded to the fax only about half the time. Of responders, the majority (82%) responded in a timely manner, within 24 hours. Most of the responses were in the form of faxed chart records. Very few responses (15% or 0.08% of all requests) were 100% complete.

Our study provides further evidence of deficiencies in communication at the time of transition. The response rate was poor. Much of the information received was either too sparse or included pages of irrelevant information (Appendix). Many of the records were not organized in a standardized manner and components were often missing. Handwriting, when used, was often illegible.

Extensive efforts have been aimed toward improving communication and information transfer between inpatient and outpatient physicians at hospital discharge and between hospital physicians during in-hospital handoffs. The Joint Commission requires completion of discharge summaries within 30 days of hospital discharge that contain the following items: problem for hospitalization, medicine reconciliation, significant findings, procedures performed, treatment rendered, condition at discharge, information to patient and family, and a follow-up plan [15]. Also to improve patient safety following discharge, the Hospital Patient Safe-D(ischarge) Project, a part of Project Boost (a quality initiative of the Society for Hospital Medicine [www.hospitalmedicine.org]), developed a “discharge bundle” consisting of medication reconciliation, discharge education, and post-discharge continuity. More attention needs to be given to an “admission bundle.”

As recommended by the Transitions of Care consensus conference, processes are needed for effective transitions of care [7]. We implemented a process that informs the PCP in a timely manner of their patient’s admission, the diagnosis, the hospital physician assuming care and where to send information. According to the consensus statement, the PCP should send, in a timely manner, a “standard data transfer form” that contains a “core set of data elements that should always be part of the transition record,” such as the one proposed in this study.

In addition, the PCP and hospitalist should also have unobstructed communication channels available that exclude answering machines and layers of office staff. Of note, a 1998 survey revealed that 77% of PCPs identified the telephone as their preferred method of communication with the hospitalist at admission and discharge [16].

The PCP responses varied in their level of organization, from poor to excellent. It is notable that one of the best organized responses was mostly handwritten, underscoring that standard organization is not dependent on the use of EMRs.

This study has several limitations. For example, although there was secretarial confirmation that the faxed request was received by the PCP office, there was no assurance that the faxed request reached the physician. It is also possible that incorrect PCP information was obtained on admission.

Further research should address adverse outcomes of inadequate information transfer at time of hospital admission, assess hospitalists’ satisfaction with PCP communication, and assess PCPs’ desires to contribute to hospital care through an open EMR. In addition, research should focus on developing standardized processes of information transfer at the time of a patient’s hospitalization. These processes should provide timely, correct, relevant information without consuming an inordinate amount of physician time. The current process of phone calls through a main office line, with multiple transfers and waiting time, is burdensome and time consuming for both physicians. The Affordable Care Act appears poised to impact health information technology development. Innovations should not lead to separate systems that produce additional barriers to communication. Let

<table>
<thead>
<tr>
<th>Item</th>
<th>Completed, n (%)</th>
</tr>
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<tbody>
<tr>
<td>Medicine list</td>
<td>31 (91)</td>
</tr>
<tr>
<td>Problem list</td>
<td>30 (88)</td>
</tr>
<tr>
<td>Allergy list</td>
<td>24 (71)</td>
</tr>
<tr>
<td>Vaccination record</td>
<td>22 (65)</td>
</tr>
<tr>
<td>Code status</td>
<td>7 (21)</td>
</tr>
<tr>
<td>Date of last visit</td>
<td>26 (76)</td>
</tr>
<tr>
<td>Response to specific inquiry</td>
<td>10/15 (67)</td>
</tr>
</tbody>
</table>
us study processes, including IT, that open lines of communication between the outpatient-inpatient setting to the benefit of patients and doctors.

Acknowledgment: The author thanks Dr. Colleen Rafferty for providing patients for inclusion in the study.

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Financial disclosures: None.

REFERENCES
Appendix. Examples of responses to hospitalist’s request for information.

A. Unhelpful response: too little information.
B. Unhelpful response: too much extraneous information.
C. Helpful response: Includes all the necessary components.