

AMERICAN ACADEMY OF PEDIATRICS

CLINICAL REPORT

Guidance for the Clinician in Rendering Pediatric Care

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Physicians' Roles in Coordinating Care of Hospitalized Children

ABSTRACT. The care of hospitalized children has become increasingly complex and intense and often involves multiple physicians beyond the traditional primary care attending physician. Pediatric and adult subspecialists and surgeons, teaching attending physicians, and hospitalists may all participate in the care of hospitalized children. This report summarizes the responsibilities of the primary care physician, attending physician, and other involved physicians to ensure that children receive appropriate, coordinated, and comprehensive inpatient care that is delivered within the context of their medical home and is appropriately continued on an outpatient basis.

BACKGROUND

The most common reasons for hospitalization of children remain acute illnesses or injuries and exacerbations of chronic illnesses or conditions. Great importance continues to be placed on limiting the duration of hospitalization and use of inpatient resources. Patients with less serious problems may be admitted for observation or short stays. Patients are discharged from inpatient units as soon as they can be appropriately cared for and their ongoing needs can be met on an outpatient basis. Although hospital costs may be decreased as a result, a shortened stay should not curtail a thorough evaluation and treatment course. Given these circumstances, the attending physician has an essential role in ensuring that the hospitalized child receives appropriate and comprehensive care that is appropriately continued on an outpatient basis. Such continuous care is a fundamental feature of health care delivered within a child's medical home.¹

As the care that is delivered on an outpatient or short-stay basis becomes more sophisticated, illnesses of hospitalized children are becoming more complex and severe and frequently require subspecialty consultation. Although the primary care physician may be the attending physician directly responsible for clinical management of the hospitalized child (see Appendix 1 for glossary of terms), this is not always the case. In community hospitals, pediatric subspecialists may be unavailable, and a physician whose primary practice is adult medicine may provide subspecialty and surgical care and function

as attending physician for pediatric patients. Alternatively, a full-time teaching attending physician, specialist, or designated hospitalist may be responsible for the supervision and care of the child.² In no case should the primary care physician be denied the opportunity to participate in the clinical care of the patient. Coordination and oversight of care must be provided by the appropriate physician(s) caring for the patient, whether that be the primary care physician or another physician(s) as described above. The following functions are the essential components of this coordination and oversight role. Each of these activities contributes materially to the care of the patient and warrants reimbursement, regardless of the specific physician(s) performing the function.

INITIAL ASSESSMENT

For any child requiring hospital admission, an initial assessment made before or at the time of hospitalization allows for the child to be admitted to the inpatient setting that is best suited to his or her specific problem(s). If the inpatient or hospital setting best suited to the child's needs is not on the approved list of the child's insurance carrier, the physicians caring for the child must advocate for the best interest of the child and seek approval for admission to the appropriate setting.³

A complete evaluation includes a history of the present illness; past medical history; pain assessment; review of systems; review of immunizations; assessment of growth, developmental, educational, and emotional status; review of family and social history, including review of behavioral and environmental risk factors; and a physical examination.⁴ The effects of the child's condition on his or her family and the effects of the family on the child's condition need to be evaluated to initiate family-centered care. These assessments may be performed just before or concurrent with hospitalization and routinely involve collaboration with other nonphysician health care professionals, such as nursing staff, child life specialists, social workers, etc.

OBTAINING HISTORY FROM THE PRIMARY CARE PHYSICIAN

It is especially important that the child's medical history be obtained when the primary care physician is not the primary attending physician. Hospital-

based attending physicians, surgeons, and subspecialists who hospitalize children with complex or multiple problems must communicate with the child's primary care physician for overall coordination of care. If necessary, this may include obtaining authorization for specific services. For children with new onset of acute problems, preexisting illness, chronic disease, and/or past hospitalizations, hospital and outpatient information must be available on admission for the inpatient health care team to review. Access to this information prevents unnecessary duplication of previous diagnostic and therapeutic measures, allows primary care and hospital-based physicians to update the status of past conditions that may not be obvious on the current admission, provides insight into psychosocial issues facing the patient and family, and facilitates monitoring the child's growth and development. Additionally, this information may indicate that a condition initially considered appropriate for a short-stay unit actually requires formal inpatient hospitalization. Inpatient and outpatient facilities must be able to provide and receive necessary medical records in a reliable, timely, safe, and confidential manner.

ONGOING ROLE OF THE PRIMARY CARE PHYSICIAN

When physicians other than the primary care physician participate in the care of the child, the primary care physician can help ensure continuity of care and help the family develop trust in providers who have no preexisting relationship with the family. When the primary care physician does not directly participate in hospital-based care, regular communication with the attending physician enables the primary care physician to remain actively involved in the patient's care. As the hospitalization progresses, the primary care physician can provide valuable insight into the patient's changing medical condition and the patient's and family's psychosocial status and response. The primary care physician can help integrate and coordinate the input of various physicians when multiple consultants are involved in the patient's care. The continued involvement of the primary care physician ensures discharge planning is proceeding effectively. It improves the primary care physician's understanding of the patient's hospital course to facilitate optimal transitional and ongoing outpatient care.⁵ For patients and families facing end-of-life issues, the involvement of the primary care physician is particularly valuable.

PEDIATRIC CONSULTATION FOR ADULT SUBSPECIALISTS AND SURGEONS

When the attending physician does not routinely care for pediatric patients, pediatric consultation can help with the physiologic, pharmacologic, and psychosocial issues unique to younger and smaller patients. The patient's primary care physician may fill this clinical role. Alternatively, another general pediatrician, or family practitioner with demonstrated consistent experience in the inpatient care of children may serve as a consultant. Such formal consultation

is particularly recommended for any hospitalized child with complex medical or psychosocial problems and all patients who are younger than 14 years or less than 40 kg in body weight.

DISCHARGE PLANS AND COORDINATION

Before discharge, an assessment of the child's needs should be made, plans should be formulated, treatment should be provided, and necessary information should be supplied to family members. Treatment plans must be made in accordance with the child's developmental, educational, and emotional level. Family members or guardians must be involved with formulation of the treatment plan, because they are ultimately responsible for decisions about the care their child receives.⁶

If treatment is not completed during hospitalization, appropriate outpatient management must be arranged. The child's social, developmental, and family status are particularly important, because most children will receive part of their treatment on an outpatient basis. The attending physician, together with other members of the health care team and the family, is responsible for evaluating whether the outpatient treatment plan appears feasible for the child's family to undertake and modifying the plan if needed. At the time of discharge, a written summary and recommendations for outpatient care must be available to all personnel and institutions involved in the future care of the child. Timely dictation services should be available to ensure a complete and legible record of events is provided. Laboratory, imaging, and consultative reports pending at the time of discharge should be specifically identified. Referrals must be provided for all needed outpatient services, including a source of primary care if the child does not have a primary care physician. In such instances or when the primary care physician was not directly involved in the child's hospitalization, the provider responsible for ongoing care should be contacted directly by the inpatient team before the day of discharge to ensure continuity of care. All referrals for outpatient services should be arranged with providers familiar with the special needs of children.⁷

Occasionally the child's physicians, when determining the need for inpatient care, may not be in agreement with decisions made by external organizations (eg, review organizations or health maintenance organizations or insurance companies). Standards of medical care established by peer groups should be used as guidelines when controversy exists with the understanding that the guidelines may not be applicable to each child's situation.⁸ In such instances, as in all instances, treatment and discharge decisions must be made with the best interest of the child as the primary motivation.

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APPENDIX 1. GLOSSARY OF TERMS

Primary Care Physician: the physician who provides the child's ongoing health care and who is responsible for the child's medical care before and after hospitalization. Most typically, this will be a general pediatrician or family practitioner practicing in an ambulatory setting. It may also be a nonphysician provider, such as a nurse practitioner or physician assistant working in conjunction with a physician, according to applicable state law. For children with chronic illnesses or special health care needs, the primary care physician may not be the typical office-based general pediatrician but could instead be a subspecialist or a physician based at a specific institution (eg, a chronic care facility).

Attending Physician: the physician on record as being responsible for the patient's care, in accordance with the individual hospital bylaws. Typically, this will be a general pediatrician or family practitioner for common medical problems. Problems that are more serious may require a subspecialist (pediatric or adult). For patients with surgical problems, that attending physician would most likely be the appropriate surgeon (pediatric or adult). Practice patterns differ by locality, and some institutions have the potential to list 2 attending physicians, most commonly a surgeon or subspecialist and a more general pediatrician or family practitioner. Full-time attending physicians, such as academic teaching attending physicians or pediatric hospitalists, can also function as the attending physician of record.

Full-Time Attending Physicians, Teaching Attending Physicians, and Hospitalists: hospital-based physicians who provide inpatient care on behalf of ambulatory-based practitioners. Models vary by community and institution, teaching status, and staff model. Other terms used to describe physicians who perform much the same role include "house pediatrician" or "in-house pediatrician." For purposes of this statement, the essential feature

is that these physicians typically do not have a preestablished relationship with the child to be hospitalized and, therefore, need background information from the primary care physician. Secondly, because these physicians will not be providing the ongoing care the patient needs after discharge, they must ensure communication with the primary care physician is appropriate.

Pediatric Subspecialists and Surgeons: pediatricians and surgeons with specific training and experience in their particular discipline and in pediatrics. As such, they can be expected to be familiar with the unique needs of children.

Adult Subspecialists and Surgeons: physicians and surgeons with expertise in the appropriate discipline but without particular pediatric expertise or experience. In these instances, consultation with a physician who has more pediatric experience may be beneficial in regard to reviewing medication and fluid orders and assisting with other medical and psychosocial issues.

REFERENCES

1. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110:184–186
2. Bellet PS, Wachter RM. The hospitalist movement and its implication for the care of hospitalized children. *Pediatrics*. 1999;103:473–477
3. Erickson LC, Wise PH, Cook EF, Beiser A, Newburger JW. The impact of managed care insurance on the use of lower-mortality hospitals by children undergoing cardiac surgery in California. *Pediatrics*. 2000;105:1271–1278
4. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2002:85
5. Lightdale JR, Mudge CL, Ascher NL, Rosenthal P. The role of pediatricians in the care of children with liver transplants. *Arch Pediatr Adolesc Med*. 1998;142:797–802
6. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2002:75
7. American Academy of Pediatrics, Committee on Child Health Financing. Guiding principles for managed care arrangement for the health care of newborn infants, children, adolescents, and young adults. *Pediatrics*. 2000;105:132–135
8. Sills MR, Huang ZJ, Shao C, Guagliardo MF, Chamberlain JM, Joseph JG. Milliman and Robertson length-of-stay criteria: are they realistic? *Pediatrics*. 2000;105:733–737

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