It used to be that community-based primary care providers (PCPs) monitored their patients when they were admitted to the hospital. However, with the development of the pediatric hospitalist in the 1990s, nowadays it is unusual for general providers to admit patients to the hospital. A recent review of the pediatric hospitalist outlined the reasons for the subspecialty: (1) the patients being admitted are more acutely ill; (2) the spectrum of patients seen in the office has changed from serious life-threatening illness to manageable chronic conditions; (3) it has become more difficult to interrupt a busy office/clinic practice when a sick child needs to be admitted to the hospital; (4) residency training includes inpatient experience, but new pediatricians prefer not to provide in-hospital care and commonly refer their admitted patients to pediatric hospitalist service; and (5) community pediatricians need to see a large volume of outpatients to be able to generate stable practice revenues.

In a recent conversation with David Irons, MD (May 2017), a friend and colleague with a general pediatric practice in Boston for more than 30 years, he expounded upon his experience as both a PCP and as a hospitalist at a children’s hospital. By working in the hospital, he maintains an understanding of how patients are managed in that setting; however, even with discharge summaries, communication between a PCP and a hospitalist is limited.

As clinicians, however, we know that communication between the PCP and the pediatric hospitalist is critical to the ongoing care and management of patients. Project IMPACT (Improving Pediatric Patient-Centered Care Transitions) is a national collaborative program designed to improve patient care transitions from hospital to home. As part of this quality improvement project, the hospitalist makes certain that discharge summaries are completed on the day of the patient’s release and sent via electronic medical record (EMR) or fax to the referring pediatrician. (Monica Joseph, MD, written communication, May 2017).

In this issue of Pediatric Annals, Dr. Laurie Wilkie, a pediatric hospitalist at the Riley Hospital for Children at Indiana University Health, and her team of contributors present a series of related articles about common illnesses for which community pediatric providers refer children for inpatient hospital management. Some of the conditions include brief resolved unexpected events, bronchiolitis, community-acquired pneumonia, and cellulitis. There are several factors, both clinical and administrative, involved in the decision-making about patient hospital admittance, such as whether caretakers can manage patient care at home, accessibility to a PCP, health literacy, and the ability to maintain adequate follow-up appointments.

For me, I tend to agree with Dr. Irons’ recent assessment: “practice used to be 90% clinical care and 10% documentation. Now it is 60% clinical care and 40% documentation!”

REFERENCES