Communication Challenges: A Qualitative Look at the Relationship Between Pediatric Hospitalists and Primary Care Providers

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ABSTRACT

OBJECTIVE: Primary care providers (PCPs) and hospitalists endorse the importance of effective communication yet studies illustrate critical communication problems between these 2 provider types. Our objective was to develop deeper insight into the dimensions of and underlying reasons for communication issues and determine ways to improve communication and remove barriers by eliciting the perspectives of pediatric PCPs and hospitalists.

METHODS: Using qualitative methods, 2 sets of focus groups were held: 1) mix of local PCPs serving diverse populations, and 2) hospitalists from a free-standing, pediatric institution. The open-ended, semistructured question guides included questions about communication experiences, patient care responsibilities, and suggestions for improvement. Using inductive thematic analysis, investigators coded the transcripts, and resolved differences through consensus.

RESULTS: Six PCP (n = 27) and 3 hospitalist (n = 15) focus groups were held. Fifty-six percent of PCPs and 14% of hospitalists had been practicing for >10 years. Five major themes were identified: problematic aspects of communication, perceptions of provider roles, push-pull, postdischarge responsibilities/care, and proposed solutions. Aspects of communication included specific problem areas with verbal and written communication. Perceptions of provider roles highlighted the issue of PCPs feeling devalued. Push-pull described conflicting expectations about a counterpart's role and responsibilities. Postdischarge responsibilities/care addressed unclear responsibilities related to patient follow-up. Proposed solutions were suggested for ways to improve communication.

CONCLUSIONS: Deficiencies in communication hinder successful collaboration and can cause tension between providers in inpatient and outpatient settings. Understanding specific issues that contribute to poor communication like perceptions about provider roles is critical to improving relationships and facilitating combined efforts to improve patient care.

KEYWORDS: communication; hospital medicine; hospitalist; pediatrics; primary care physician; qualitative research

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WHAT'S NEW

Communication between primary care providers and hospitalists surrounding patient hospitalization is fraught with challenges. This study offers insight into causes of these issues from primary care provider and hospitalist perspectives, helping to fill the knowledge gap and inform improvement efforts.

WITH THE GROWTH of pediatric hospital medicine, care of the hospitalized patient is commonly provided by an inpatient physician (eg, hospitalist) who is not the patient's primary care provider (PCP). The trend toward inpatient specialization has made reliable and effective communication between PCPs and hospitalists more challenging and of utmost importance.[1–3] The 2010 and 2013 American Academy of Pediatrics policy statements,[3,4] and the 2009 Transitions of Care Consensus Policy Statement[5] acknowledge the significance and effect of communication between inpatient and outpatient providers.

Patient care during admission, hospitalization, and discharge requires a transfer of information and responsibility between inpatient and outpatient providers. The Joint Commission cites communication failures between providers as the root cause for approximately 60% of sentinel events.[6] Investigators have cited multiple communication issues between inpatient and outpatient settings that require attention: poor quality of and barriers to communication; provider and patient/family dissatisfaction; variable methods of information sharing; unstandardized communication; and unclear ideal timing of communication.[7–9] These issues have been investigated via primarily quantitative survey studies[8–10] and 2 mixed methods studies.[7,11]

The perceived poor quality of communication is evident in a pediatric study in which no hospitalists or PCPs rated

communication quality as excellent, 10% of hospitalists and 42% of PCPs rated it as very good, and 33% of PCPs rated the communication as poor.[7] Hospitalists cited the lack of a PCP directory, access to patient medication and problem lists, and a standardized communication system as the greatest barriers. PCPs shared concerns regarding how to contact the hospitalist caring for their patients and the complexities of navigating a teaching hospital.[7]

There is no consensus for the preferred mode, content, or timing of communication and information exchange. The electronic medical record (EMR) is envisioned as an ideal forum,[7] but a survey revealed e-mail as the most preferred communication mode followed by phone, fax, and discharge summary.[9] Findings from other studies reflect a lack of consensus regarding preferences for discharge communication content,[5,7,10–12] which makes standardization challenging.

Despite these findings, a gap remains as to why these communication challenges persist. To develop effective and long-term interventions to address communication barriers, we took this investigation beyond the enumeration of communication problems between PCPs and hospitalists. Our objectives were to: 1) thoroughly explore and describe aspects of communication issues, 2) identify and explain factors that contribute to communication issues, and 3) describe potential solutions to address communication issues as discussed by PCPs and hospitalists via focus groups.

METHODS

SETTING

This was an institutional review board-approved study at Cincinnati Children's Hospital Medical Center (CCHMC), a free-standing, academic children's hospital with approximately 500 beds and a pediatric residency program with approximately 180 residents. From 25 surrounding counties, 400 PCPs refer to CCHMC for general pediatric inpatient care, and 100 have admitting privileges; the remainder admit to the Hospital Medicine service. Caring for approximately 8000 inpatients per year, the Hospital Medicine Division is composed of >40 providers who devote most of their clinical time to the Hospital Medicine service and 15 providers who work on the Hospital Medicine service but have primary clinical responsibilities in another division.

STUDY POPULATION AND RECRUITMENT

PCPs

To elicit diverse views, PCPs with and without admitting privileges were recruited to participate in focus groups using multiple strategies. The Executive Community Physician Leader, a faculty member tasked with strengthening the hospital's relationship with community providers, advertised for the focus groups via e-mail and other publications. The Physician Services Office, a liaison between CCHMC and community-based providers, promoted the focus groups in their communications with PCP practices. PCPs were also contacted directly via e-mail by the primary investigator (PI). Additionally, pediatric residents were encouraged to invite their continuity clinic preceptors to participate.

HOSPITALISTS

Hospitalists were invited to participate during divisional meetings and via e-mail.

Consent was verbally obtained during the focus groups. Participants received no monetary incentive or reimbursement for time, but food and beverages were provided at each focus group meeting.

DATA COLLECTION

Before embarking on our study, we surveyed local PCPs and hospitalists about satisfaction with overall communication. Survey results facilitated the design of this qualitative study, where we were able to explore the rationale behind some of the survey responses. The qualitative framework of this study allowed for an in-depth evaluation from the perspectives of PCPs and hospitalists, generated hypotheses aimed at improving communication barriers, and informed the creation of mutually beneficial interventions.

PCPs and hospitalists participated in separate provider-specific focus groups, allowing participants with similar backgrounds to comfortably share thoughts and experiences. The PI (L.G.S.) developed semistructured, open-ended question guides for the focus groups with input from a qualitative methodologist (S.N.S.) and a clinical content expert (J.M.S.). Question guides were designed to stimulate discussion and allow participants to answer in their own words, thereby identifying salient issues. Question guides for PCPs and hospitalists included similar questions, adapted for differences between provider settings (Supplementary Appendixes 1a and 1b). The qualitative methodologist, not known to participants, moderated each focus group session and used probes and follow-up questions to clarify, expand, and explore participants' responses. Question guides were modified in an iterative fashion to include new issues raised in focus groups.[13–15]

Of the 6 PCP focus groups, 5 were held at office-based practices, and 1 was held at CCHMC. Hospitalist focus groups were held at CCHMC. Participant demographic characteristics were collected at each focus group using a self-administered anonymous survey. Focus groups were approximately 45 to 60 minutes in length, held in private conference rooms, audio-recorded, and transcribed verbatim by a third party professional transcription company. The PI redacted any identifying information that was inadvertently mentioned or recorded after transcription.

DATA ANALYSIS

An inductive, thematic analysis approach[13,14,16] was used for interpretation of the data, and each provider group was analyzed separately. To identify emerging concepts, analysis began with the independent review of 1 transcript by the qualitative methodologist and the PI trained in qualitative methods. The 2 analysts met to discuss, identify, define, and organize concepts as codes,