



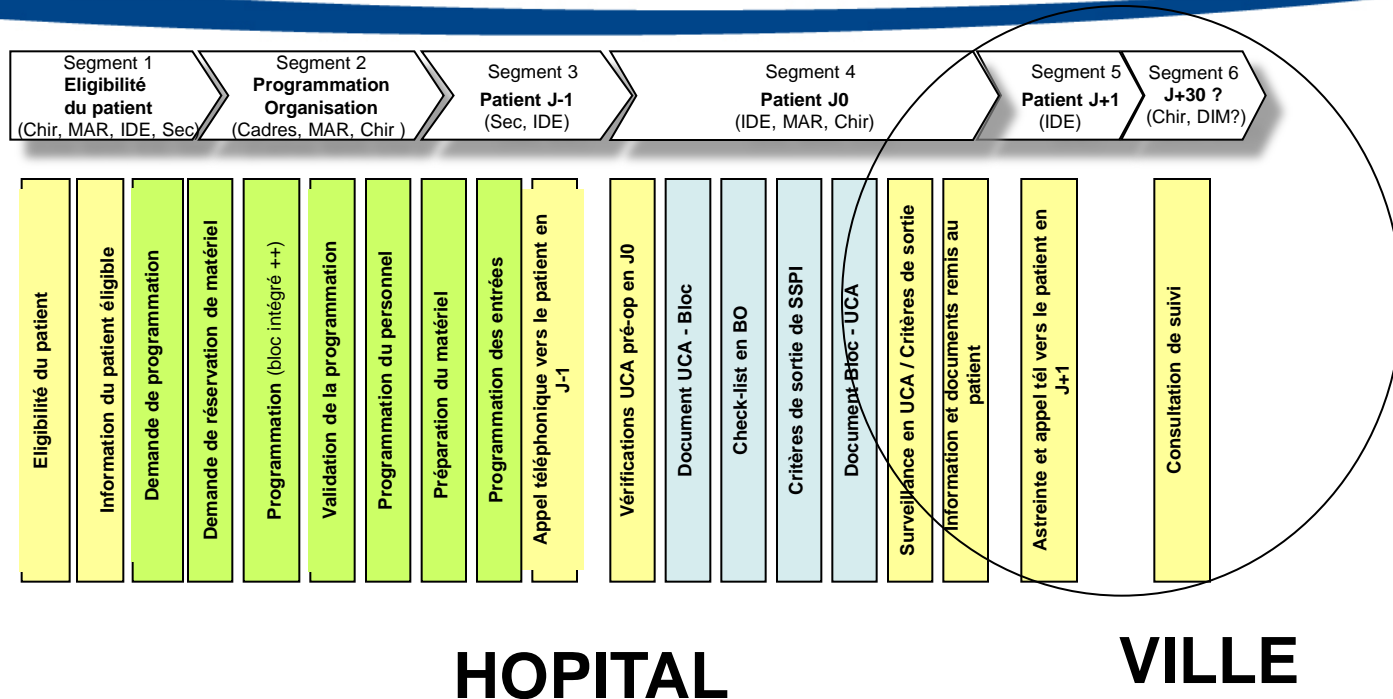
HAUTE AUTORITÉ DE SANTÉ

Transfert sur la médecine de ville des problèmes hospitaliers

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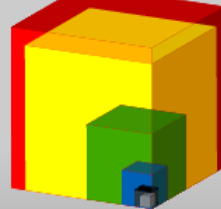
L'ambulatoire est emblématique d'une médecine du parcours



Le pivot d'une médecine de parcours réussie n'est pas l'hôpital mais le médecin de ville

«In hospitals, diseases stay and patients come and go; in general practice, patients stay and diseases come and go »

Carré de White



The Health Care Ecology Model

OCCASIONAL NOTES

Occasional Notes

THE ECOLOGY OF MEDICAL CARE REVISITED

SINCE its publication in the *Journal* in 1961, "The Ecology of Medical Care," by White et al.,¹ has provided a framework for thinking about the organization of health care, medical education, and research (Fig. 1). This conceptualization, inspired in part by careful reporting on the part of British general practitioners,² suggested that in a population of 1000 adults, in an average month, 750 reported an illness, 250 consulted a physician, 9 were hospitalized, 5 were referred to another physician, and 1 was referred to a university medical center. These data have been used repeatedly by investigators, authors of textbooks, task forces, and government agencies.³⁻⁹ The 1961 report was based on multiple sources of information, mostly from the United States and Britain, dating from 1928. Some of the estimates were subsequently characterized as "intelligent guesses," with the truth unknown.¹⁰

In 1961, the number of general practitioners in the United States was in steep decline, and the overall number of physicians and the number of subspecialties were growing rapidly. Medicare and Medicaid had yet to be created. Much of the current medical armamentarium, such as computed tomography, organ transplantation, endoscopy, effective antidepressant drugs, and coronary artery bypass surgery, had not been developed. Nurse practitioners, physician assistants, and the specialty of family practice did not exist.

Much has changed in medicine and in the organization and financing of health care since 1961. Some of these changes — such as new medications and forms of technology, increased expenditures, managed care, and changes in the medical work force — might be expected to have altered the ecology of medical care.¹¹⁻¹⁸ There have also been substantial improvements in the collection and reporting of data on health care in the United States.¹⁹⁻²¹ We have updated the 1961 report by White et al. and have also extended the original study to incorporate data on children and additional sites and types of health care services. Like White, who revised the model in 1973,²² and Thacker and colleagues, who used a longitudinal approach in applying it to a rural setting,²³ we found some variation but overall stability of the relationships proposed 40 years ago.

METHODS

Data
We used the 1996 Medical Expenditure Panel Survey because it contains the most recent, nationally representative data on most of the components of utilization included in the 1961 analysis. Reported data on households cover demographic characteristics, health conditions, health status, use of medical services, and

payments for services, access to care, satisfaction with care, health insurance coverage, income, and employment.²⁴ Of the respondents to the 1996 National Health Interview Survey who were selected for inclusion in the subsequent Medical Expenditure Panel Survey, 83.1 percent participated in the first round of data collection in 1996. Data in the survey can be adjusted with the use of weights to make inferences about national trends.²⁴ Although the survey is a remarkably comprehensive source of information on health care utilization, it did not meet all our needs. Consequently, we collected additional data using a short survey administered by the Gallup Organization.²⁵

The Gallup survey was based on telephone interviews with adults in 1001 households. This nationally representative sample was selected through random digit dialing, with three attempts made to contact a potential respondent before another was chosen. Data were collected for 1001 adults and 490 children who resided in the surveyed households. Not more than two children per household, the youngest and oldest, were included. Interviews were conducted between April 23 and May 7, 2000. The Gallup survey was the primary source of data for estimating the number of people who had considered seeking health care in the previous month and who had received care from a complementary or alternative medical care provider, excluding use of alternative treatment without a visit to a provider.

The Gallup Organization provided weighting factors (to permit inferences to be made for the U.S. population) and estimates of sampling errors, making possible the calculation of national estimates and providing the range within which estimates might vary. The largest 95 percent confidence interval in this study was the 1.3 percent range for the estimate of the number of persons who had considered seeking health care in a one-month period. For estimates based on the Medical Expenditure Panel Survey, the largest 95 percent confidence interval was 211.6 to 222.4 for the number of persons per 1000 who had visited a physician's office in a one-month period.

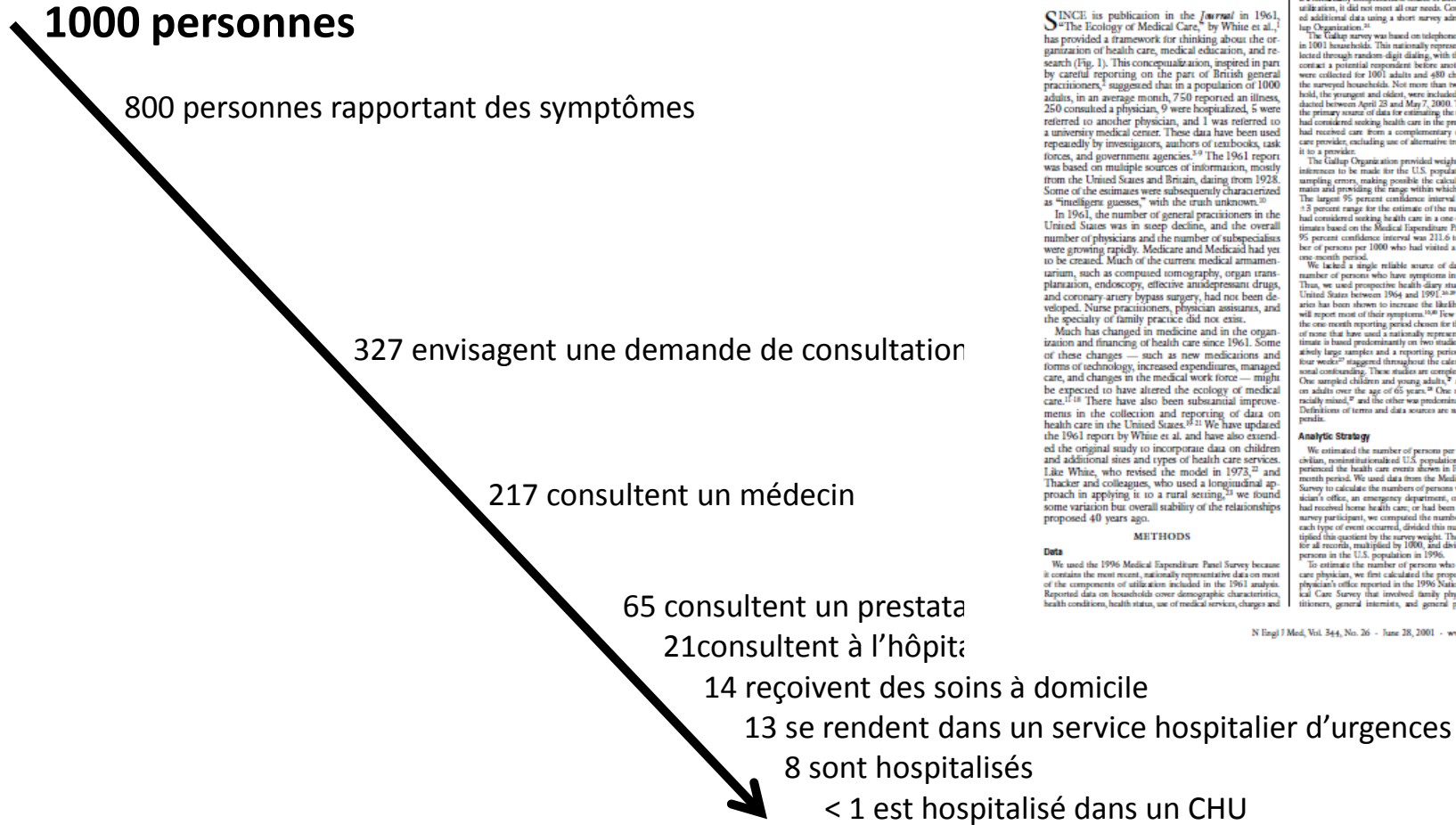
We lacked a single reliable source of data for estimating the number of persons who have symptoms in a one-month period. Thus, we used prospective health diary studies conducted in the United States between 1964 and 1991.²⁶⁻²⁹ The use of health diaries has been shown to increase the likelihood that respondents will report most of their symptoms.³⁰ Few such studies have used the one-month reporting period chosen for this study, and we know of none that have used a nationally representative sample. Our estimate is based predominantly on two studies^{27,28} that involved relatively large samples and a reporting period of three weeks²⁷ or four weeks²⁸ assigned throughout the calendar year to avoid seasonal confounding. These studies are complementary in other ways. One sampled children and young adults,²⁷ and the other focused on adults over the age of 65 years.²⁸ One sample was urban and racially mixed,²⁷ and the other was predominantly rural and white.²⁸ Definitions of terms and data sources are summarized in the Appendix.

Analytic Strategy

We estimated the number of persons per 1000 members of the civilian, noninstitutionalized U.S. population in 1996 who had experienced the health care events shown in Figure 2 during a one-month period. We used data from the Medical Expenditure Panel Survey to calculate the numbers of persons who had visited a physician's office, an emergency department, or an outpatient clinic; had received home health care; or had been hospitalized. For each survey participant, we computed the number of months in which each type of event occurred, divided this number by 12, and multiplied this quotient by the survey weight. The product was summed for all records, multiplied by 1000, and divided by the number of persons in the U.S. population in 1996.

To estimate the number of persons who had visited a primary care physician, we first calculated the proportion of all visits to a physician's office reported in the 1996 National Ambulatory Medical Care Survey that involved family physicians, general practitioners, general internists, and general pediatricians. We then

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EST-CE un problème?

Interfaces avec l'hôpital

1. Seulement 3 % des médecins généralistes sont impliqués dans les décisions de retour à domicile des patients hospitalisés,
2. 17 à 20 % d'entre eux sont prévenus quand leurs patients rentrent chez eux,
3. Moins de 20 % reçoivent un compte rendu au bout d'une semaine,

Kripalani S., LeFevre F., Phillips C.O., Williams M.V., Basaviah P., E
information transfer between hospital-based and primary care physicians. JAMA 2007 ;297 :831-41

REVIEW

Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians Implications for Patient Safety and Continuity of Care

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AS THE SPECIALTY OF HOSPITAL medicine expands, the transfer of responsibility for patient care between hospital-based physicians (hospitalists) and primary care physicians becomes increasingly common, creating an urgent need to improve communication and information transfer between inpatient and outpatient physicians at hospital discharge.¹⁻³ Timely transfer of accurate, relevant data about diagnostic findings, treatment, complications, consultations, tests pending at discharge, and arrangements for post-discharge follow-up may improve the continuity of this handoff.^{4,5} By contrast, delayed communication or inaccuracies in information transfer among health care professionals, particularly during the early postdischarge period, may have substantial implications for continuity of care, patient safety, patient and clinician satisfaction, and resource use.^{6,10}

The discharge summary is the most common method for documenting a patient's diagnostic findings, hospital management, and arrangements for postdischarge follow-up. The Joint

Contact Delayed or inaccurate communication between hospital-based and primary care physicians at hospital discharge may negatively affect continuity of care and contribute to adverse events.

Objectives To characterize the prevalence of deficits in communication and information transfer at hospital discharge and to identify interventions to improve this process.

Data Sources MEDLINE (through November 2006), Cochrane Database of Systematic Reviews, and hand search of article bibliographies.

Study Selection Observational studies investigating communication and information transfer at hospital discharge (n=55) and controlled studies evaluating the efficacy of interventions to improve information transfer (n=18).

Data Extraction Data from observational studies were extracted on the availability, timeliness, content, and format of discharge communications, as well as primary care physician satisfaction. Results of interventions were summarized by their effect on timeliness, accuracy, completeness, and overall quality of the information transfer.

Data Synthesis Direct communication between hospital physicians and primary care physicians occurred infrequently (3%-20%). The availability of a discharge summary at the first postdischarge visit was low (12%-34%) and remained poor at 4 weeks (51%-77%), affecting the quality of care in approximately 25% of follow-up visits and contributing to primary care physician dissatisfaction. Discharge summaries often lacked important information such as diagnostic test results (missing from 33%-63%), treatment or hospital course (7%-22%), discharge medications (2%-40%), test results pending at discharge (65%), patient or family counseling (90%-92%), and follow-up plans (2%-43%). Several interventions, including computer-generated discharge summaries and using patients as couriers, shortened the delivery time of discharge communications. Use of standardized formats to highlight the most pertinent information improved the perceived quality of documents.

Conclusions Deficits in communication and information transfer at hospital discharge are common and may adversely affect patient care. Interventions such as computer-generated summaries and standardized formats may facilitate more timely transfer of pertinent patient information to primary care physicians and make discharge summaries more consistently available during follow-up care.

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www.jama.com

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Interfaces avec l'hôpital

1. Dans un quart des cas, ce compte rendu n'arrive jamais chez le médecin traitant,
2. 38 % des résumés de sortie ne font pas état des résultats de laboratoire et 21 % des traitements prescrits.
3. Mais les médecins de premier recours ne communiquent pas suffisamment d'informations quand ils adressent leurs patients aux spécialistes.

Kripalani S., LeFevre F., Phillips C.O., Williams M.V., Basaviah P., Baker D.W. *Deficits in communication and information transfer between hospital-based and primary care physicians*. JAMA 2007 ;297 :831-41

Dysfonctionnements dans la planification de la sortie de l'hôpital et dans les soins de transition

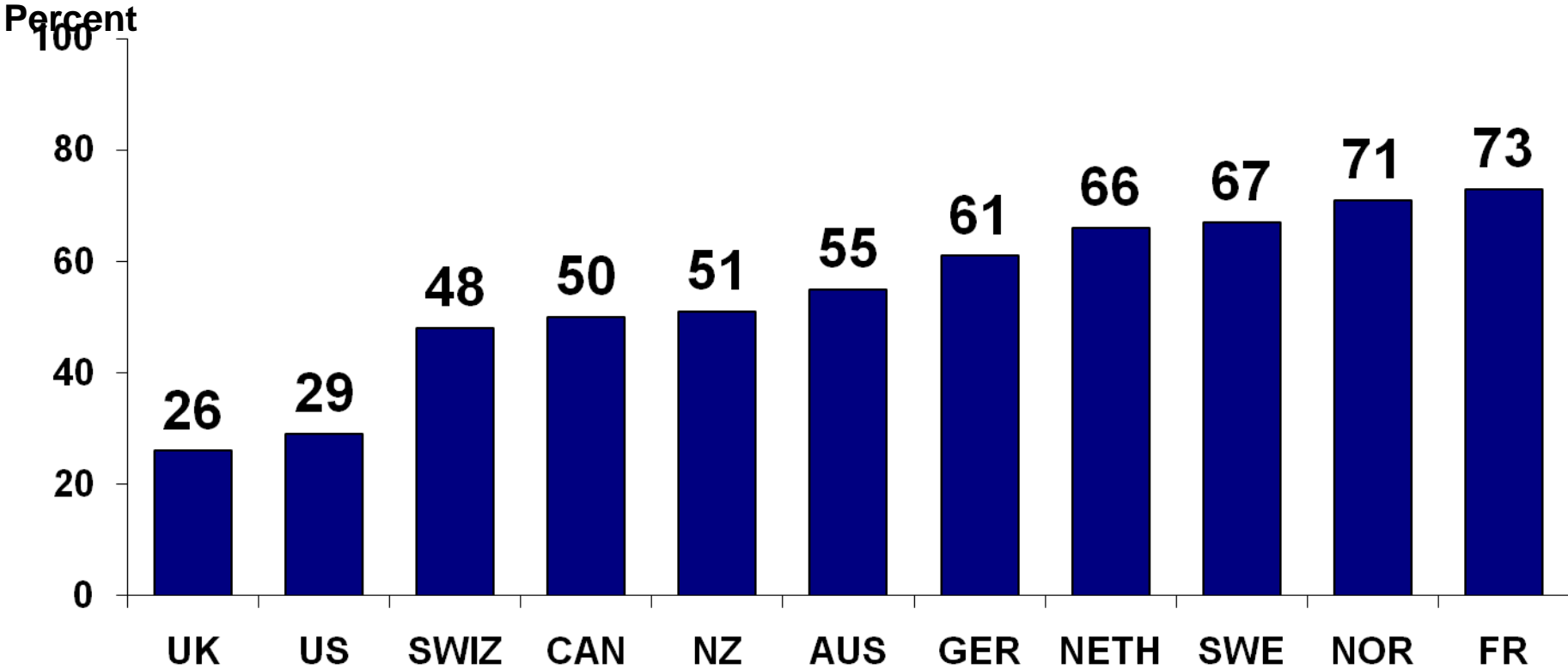
Base : Adultes qui ont été hospitalisés dans les 2 dernières années

%	AUS	CAN	FR	ALL	PB	NZ	RU	EU
N' ont pas reçu de consignes sur les symptômes à surveiller et quand avoir recours à des soins additionnels	25	20	37	29	24	28	26	12
Ne savaient pas qui contacter pour des questions sur leur état ou leur traitement	15	11	16	11	13	14	17	8
N' avaient pas de plan écrit pour les soins après la sortie	43	29	39	40	37	31	32	9
L' hôpital n' avait pas pris des dispositions pour un suivi par un médecin	38	32	40	35	21	32	27	28
Un de ces dysfonctionnements	61	50	71	61	51	53	50	38

Data collection: Harris Interactive, Inc.

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults

Gaps in Hospital or Surgery Discharge in Past Two Years



* Last time hospitalized or had surgery, did NOT: 1) receive instructions about symptoms and when to seek further care; 2) know who to contact for questions about condition or treatment; 3) receive written plan for care after discharge; 4) have arrangements made for follow-up visits; and/or 5) receive very clear instructions about what medicines you should be taking.

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.





**L'ambulatoire prévoit le processus de
décharge sécurisé du patient mais minimise
le rôle du médecin généraliste**

**POURQUOI CETTE DIFFICULTE
PERSISTANTE ?**

Pourquoi sous estimer le rôle du généraliste ?

- 1. Explications jugées claires données au patient, pas besoin de rappeler le généraliste**
- 2. Consignes de rappeler l'hôpital en cas de problème**
- 3. Méconnaissance du domaine de ville et de la médecine de parcours**

Health Literacy / Compréhension des patients

- 1. Les consignes sont loin d'être toujours comprises**
- 2. Tout le monde n'est pas égal dans son niveau intellectuel et son niveau d'éducation scolaire.**
 - Plus de 30% des français, ont, au mieux, le niveau certificat d'étude. 36% des citoyens ne savent pas utiliser des données simples, et 58% sont perdus dans les comparaisons de pourcentages. Ces risques sont encore aggravés par le vieillissement et la dégradation des capacités sensorielles.
- 3. Le patient est toujours anxieux, d'autant plus que ce qu'on lui dit est nouveau et important pour sa santé**

Quelle conséquence si le patient comprend mal?

1. Un problème de sécurité

- Plus de 50 %des patients ne prennent pas ou prennent mal le traitement prescrit : pas compris, pas saisi l'importance du médicament, de sa dose maximale ou minimale, de sa façon de le prendre...

2. Un coût considérable

- 200 milliards de \$ US sont perdus chaque année aux USA par le fait d'une mauvaise compréhension et d'un mauvais suivi des consignes par les patients.
- Les patients qui ont des difficultés de compréhension coûtent en moyenne trois à quatre fois plus chers à la société que ceux qui ont de bonnes capacités cognitives et ils ont finalement un taux de mortalité supérieur.
 - Ils sont victimes d'une double peine
 - (1) par des conseils souvent plus rapides et des prescriptions médicales souvent simplifiées du médecin pour s'adapter à la difficulté perçue (compréhension, manque de fiabilité dans les rendez-vous, difficultés sociales et financières, etc.) qui se traduisent par des traitements moins efficaces par rapport à ceux donnés aux autres patients
 - (2) et un faible suivi par ces patients des instructions données et des tests de prévention et de toutes natures proposées par le médecin.

Suivi de la qualité à domicile des sorties : la partie médicale

1. **Suivi initial du traitement prescrit pratiquement exhaustif ... mais « adapté » : 18% ont changé des traitement ou pris des traitements adaptés (douleur notamment)**
 2. **82% sont sortis avec une ordonnance d'antalgique; 9 à 25% ne les ont pas pris du tout, 17 à 28% ont souffert**
 3. **Beaucoup plus rarement, difficulté à reprendre certain traitement antérieur (antidiabétique, ...antiépileptique, lithium..) fenêtre de deux ou trois jours pendant la période immédiatement de retour à domicile en attendant de revoir le médecin traitant**
-
1. **Source : mémoires du Mastere de sécurité des soins, Toulouse, 2012-2013**

Suivi de la qualité à domicile des sorties : rappels

1. Trouver les soignants
2. Réassurance de prescriptions adaptées par le médecin traitant
3. Inquiétude liées aux INTERDITS post op
4. Selon les études, 22% à 41% des appels sont reconduits par l'hôpital sur un médecin généraliste (qui répond?). Ce chiffre augmente après J1
5. Intention d'appel en cas de problème suite à l'intervention : médecin traitant (35%), IDE a domicile (30%), Chirurgien ou service d'hospitalisation (28%), ne savent pas et appellent le 15 ou un service d'urgence (7%)

Source : mémoires du Mastere de sécurité des soins, Toulouse, 2012-2013



Une forte actualité et une forte ambition nationale

Une forte actualité sur le sujet : le PNSP (2012-2017)

Axe 1 : Information au patient, patient coacteur

OBJECTIF GENERAL n° 2 Mieux informer le patient

Objectif opérationnel 2.1. Mieux communiquer avec le patient au moment de sa sortie d'établissement

2.1.1 Elaboration et expérimentation d'un document de sortie type, synthèse du séjour du patient, lisible par lui, possiblement implémenté dans le système d'information, remis systématiquement à tout patient lors de sa sortie dans le but d'assurer la continuité de la prise en charge

Axe 2 : améliorer la déclaration et la prise en compte des évènements indésirables associés aux soins

Axe 3 : formation, culture de sécurité, appui

Axe 4 : innovation, recherche



CONCLUSION

- 1. Le retour vers le médecin traitant est la norme et non l'exception : c'est le cœur du système de parcours**
- 2. Son (in)formation est essentielle**
- 3. Portage direct ou par le patient**
- 4. Rencontres et explications sont nécessaires (réseautage actif)**