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An organizational model for patient flow and continuity of care in internal medicine

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Dear Editor,

The changing profile of patients admitted to Internal Medicine is prompting renewed reflection on how hospital care should be organized. In a recent contribution to the Italian healthcare debate, FADOI President Andrea Montagnani highlighted the limitations of defining Internal Medicine as a "low-intensity" setting, drawing attention to the clinical and organizational complexity associated with multimorbidity and frailty.[1] Indeed, intensity of care and patient complexity represent related but distinct dimensions. Patients who do not require highly intensive monitoring may nevertheless have substantial care needs resulting from multimorbidity, functional impairment, polypharmacy, cognitive vulnerability, and social complexity.[2,3]

Frailty further increases vulnerability to acute stressors and makes coordination throughout the care process particularly relevant.[2] An organization based solely on intensity of care may therefore not fully capture the needs of contemporary internal medicine patients, particularly when these needs extend beyond the acute phase of hospitalization. This consideration supports a broader organizational perspective in which intensity of care is integrated with attention to patient trajectories and continuity across care settings.

Importantly, internal medicine should not be primarily identified with low-intensity care or discharge management. Internists play a central role in the acute management of complex and multimorbid patients, whose clinical conditions frequently require diagnostic integration, therapeutic prioritization, and repeated reassessment of competing clinical needs. The absence of a requirement for intensive monitoring or advanced organ support does not necessarily imply lower clinical complexity or reduced medical workload. From this perspective, continuity of care should be understood as an integral extension of acute medical management, rather than as a separate function predominantly focused on discharge.

Within the Continuity Internal Medicine Unit of the University Hospital of Parma, these considerations have progressively shaped an organizational approach in which the management of the acute condition is integrated with early attention to the subsequent phases of the patient's care pathway. Functional and social needs, discharge planning and the identification of the most appropriate post-hospital setting are therefore considered from the early stages of hospitalization, in line with evidence supporting comprehensive assessment, early discharge planning and coordinated transitions of care in older and complex patients.[4-6]

Early assessment should extend beyond the definition of the acute clinical problem to include the factors that may influence the subsequent course of hospitalization and the transition to the most appropriate care setting. Integrating clinical evaluation with functional and social assessment may allow care needs and potential barriers to discharge to be recognized at an early stage. Comprehensive geriatric assessment provides a well-established framework for this approach by integrating medical, functional, cognitive and social dimensions in the management of older patients.[5,7]

These principles have progressively shaped our organizational experience, in which the management of acute clinical needs is integrated with early consideration of functional and social needs and with planning for the subsequent phases of care. Multidimensional assessment, definition of diagnostic and therapeutic goals, discharge planning and coordination with general practitioners, caregivers and community services are therefore approached as interconnected components of the same care pathway.[4,6,8] This integrated approach is particularly relevant for frail and multimorbid patients, whose needs often persist beyond the resolution of the acute condition and require continuity across different care settings.[6,8]

In our experience, this approach also requires close multidisciplinary collaboration. Physicians, nurses, healthcare assistants, social workers and community professionals contribute, according to their respective roles, to the different stages of the care pathway. Their coordination throughout hospitalization facilitates the early identification of post-discharge needs and supports continuity during the transition between hospital and community care.[5,8]

The hospital-community interface therefore represents a central component of this organizational approach. Clinical stabilization may not be sufficient to ensure an appropriate transition when functional or social needs persist, follow-up has not been adequately defined, or community support needs to be activated. Incorporating these aspects into the hospital care process may reduce fragmentation and support a more coordinated transition across healthcare settings.[8,9] Nevertheless, effective continuity of care cannot depend exclusively on the efforts of individual clinicians or hospital departments. It requires shared responsibility across the healthcare system, supported by structured care pathways, dedicated transitional care resources, and effective multidisciplinary collaboration between hospital and community professionals. Without adequate organizational integration and accessible community services, even well-coordinated hospital care may be insufficient to ensure timely and appropriate transitions for complex patients. Patient flow has consequently been considered in a broader sense than the acceleration of discharge or optimization of bed turnover. It involves anticipating the subsequent phases of care and aligning clinical decisions, discharge planning and available hospital and community resources throughout the patient's pathway.

This perspective does not replace an organization based on intensity of care. Our experience rather suggests that intensity of care can be integrated with an additional organizational dimension focused on the evolution of patients' needs throughout hospitalization and across care settings. Intensity of care remains essential for matching clinical needs with appropriate levels of monitoring and assistance, while attention to patient flow and continuity may facilitate the anticipation and coordination of subsequent phases of care.

This integration appears particularly relevant in contemporary Internal Medicine, where patient complexity frequently reflects the interaction of multimorbidity, functional impairment, frailty and social factors.[2,3] Consequently, the resources required for appropriate care cannot always be fully represented by the severity of the acute condition or by intensity of care alone. Multidisciplinary assessment, discharge planning and coordination with community services are integral components of the management of these patients and contribute to the overall organizational complexity of internal medicine.[5,8,9]

Our experience also raises a broader question regarding how the activity and performance of Internal Medicine units should be evaluated. Traditional indicators, such as length of stay, bed occupancy, and patient turnover, remain relevant but provide only a partial representation of the clinical and organizational workload associated with complex patients. A more comprehensive evaluation framework should incorporate measures of multimorbidity, frailty, functional dependency, and clinical outcomes, alongside risk-adjusted readmission rates and indicators of the quality and timeliness of care transitions. Importantly, these measures should be interpreted in relation to patient case mix and available resources, avoiding the unintended penalization of departments caring for the most vulnerable populations.

Ultimately, recognizing clinical complexity must translate into tangible organizational consequences. Staffing levels, multidisciplinary expertise, resource allocation, and funding models should reflect not only the intensity of monitoring or treatment but also the burden of multimorbidity, frailty, and care coordination. Failure to account for these dimensions risks underestimating the actual workload of Internal Medicine departments and perpetuating a mismatch between patient needs and available resources. The future of hospital Internal Medicine therefore depends on recognizing its dual responsibility: providing comprehensive care for acute, complex patients while ensuring continuity across the entire healthcare pathway.

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