Improving Communication at Hospital Discharge: Patient Teaching, Contact with Primary Care Providers, Follow-up Planning

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Background – Discharge Planning

Transitions of care present a number of challenges and are high risk points in the care continuum. Clear communication with the patient and their primary provider about follow-up plans is vital to ensure a safe transition from the hospital to outpatient setting. Unfortunately, too often:
- Hospital physicians do not directly communicate with PCPs.
- Discharge summaries are delayed and incomplete, which can contribute to missed follow-up and adverse events.
- Physicians do not communicate clearly with patients.

Discharge checklists provide a consistent framework in order to facilitate early planning and multidisciplinary collaboration. Common domains among evidence-based checklists include:
- Communication with outpatient providers.
- Medication safety.
- Patient education.
- Home care.

In one study, providers were trained to provide teaching, communicate with PCPs, and ensure follow-up. ED visits and readmission rates were significantly decreased and total cost of care was reduced by 30% for the intervention group. Additionally, the Affordable Care Act provides financial incentive for improved patient education and safe discharge.

Goals

Using a multidisciplinary discharge checklist built into our electronic medical record, we aimed to accomplish 3 checklist tasks in 85% of patients discharged:
- Phone or written contact with PCPs.
- Direct discharge teaching by an MD.
- A specific follow-up in place.

Methods – Checklist Tool

The discharge checklist is a multidisciplinary navigation tool built into the Epic EMR, which allows providers to document progress toward discharge goals. Contents of the checklist include a patient handout summarizing diagnosis, home care instructions, medications, and follow-up plans.

Methods – Interventions & Survey

Sept 2012:
- Resident focus group to discuss anticipated project barriers
- Printed reminders
- In-person instruction

Jan 2013:
- Personal feedback to team members regarding performance
- Printouts of team performance directly to teams

March 2013:
- Residents on service from Sept 2012-March 2013 were surveyed regarding their perspectives about discharge planning and use patterns of the checklist.

Results

Survey

>90% of residents agree or strongly agree that:
- “In-person MD teaching is an important part of safe discharge.”
- “Specific follow-up in place is a valuable part of hospital discharge.”
- “Phone contact with PCPs is a valuable part of hospital care.”
- >80% of residents agree or strongly agree with the statements:
  - “I found the discharge checklist to be valuable during the discharge planning process.”
  - “Use of the discharge checklist took away from time spent on other patient care tasks”

Top 5 barriers to use of the checklist:
1. Not a natural part of the workflow.
2. Non-MD providers not using the checklist.
3. Time was better spent on other work.
4. Difficulty contacting PCPs.
5. Checklist is difficult to navigate.

Conclusion

Residents can take ownership of discharge teaching and communication with PCPs, though they would be more likely to consistently use a checklist which is integrated into the normal workflow.

Next Steps

To make tasks a natural part of the workflow and move beyond “clicking boxes”, we plan to focus on MD teaching through improving the quality of written discharge instructions.

Other components of the current discharge navigator will be absorbed into a new automated discharge “readiness” report. Measures of discharge readiness will change from RED to GREEN as team members prepare patients for discharge.

Resources