Improvement in communication of transferred patients to a tertiary care facility to referral physicians/nurseries for improved provider satisfaction

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Introduction

•Communication with referral physicians after patients are transferred from a referral hospital to a tertiary care center rarely occurs.

•Lack of communication may lead to misunderstanding in long-term care, misperceptions, medical errors, decreased transfers, denial of back transports, change in referral patterns and loss of patient and provider satisfaction.

•Improvement in communication between providers can lead to improved outcomes and improved professional relationships.[1]

•Each month, approximately 20 acute neonatal transports occur to VMC.

•At VMC, there was not an existing process or practice for communicating with referring physicians of transferred patients.

•Regional providers have expressed an interest in receiving updates and feedback on infants transferred to VMC.

•Previously, some of the transport nurses provided updates as an educational effort.

•Providers have not expressed a preference in how the information is received, as long as updates are given.

Aim Statement

Specific Aim: Improve communication by 50% in the next 6 months to referral physicians requesting neonatal transport via Eastcare or other Children's hospital transport team to VMC via written/phone communication within 1-5 days of admission, discharge and monthly for patients with long lengths of stay to improve satisfaction and continued referrals.

Acknowledgements

The Teachers of Quality Academy program was developed with financial support from the American Medical Association as part of the Accelerating Change in Medical Education Initiative.

This poster was prepared with financial support from the American Medical Association.

Methods

Fishbone diagram of the process to improve communications

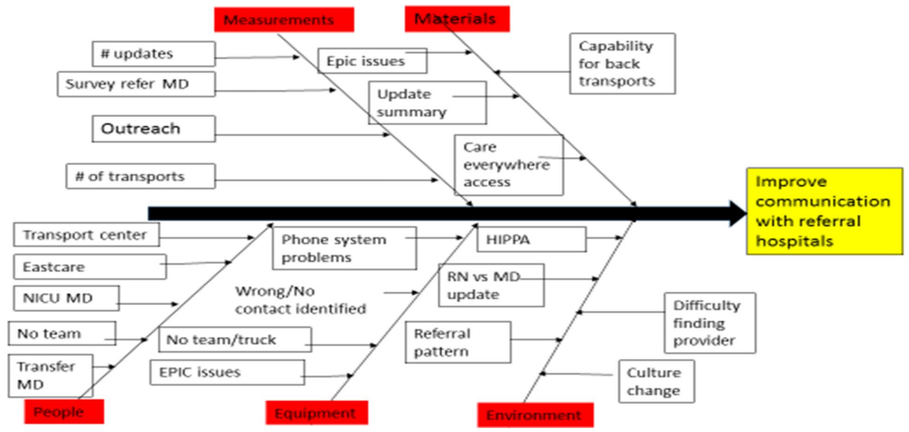


Table 1 Initial PDSA cycles

PDSA Cycle	Intervention	Outcome
PDSA Cycle 1	Feasibility of using EMR for letters/updates to providers	Not feasible as some providers are unable to download to their EMR
PDSA Cycle 2	Determine if contact information correct	Updated some of the contact information in our list
PDSA Cycle 3	Call and create MD database	Not all providers full-time, some nurseries difficulty determining MD
PDSA Cycle 4	Determine how patients are tracked for referral	Spreadsheet created to record and track when information given
PDSA Cycle 5	No formal database for transport sheets	Administrative assistant collects and emails sheets daily
PDSA Cycle 6	Create process for written updates to referral physicians/nurseries	Determined correct fax number and sheets are sent within 1-5 days

Results

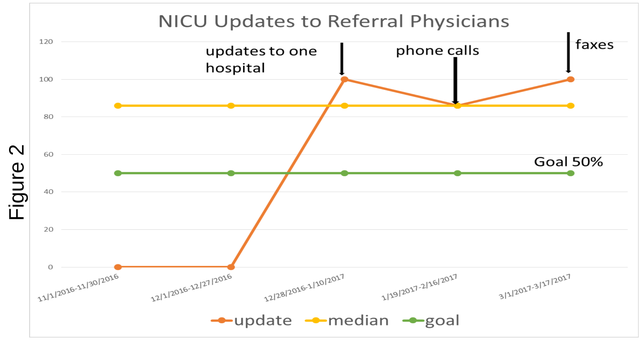
Pilot Cycle	Intervention	Outcome
Pilot Cycle 1	Initial follow-up phone calls to NHRMC	Able to update providers on multiple infants transferred in one call
Pilot Cycle 2	Called outside providers to update	Most calls successful, but occasionally unable to find MD
Pilot Cycle 3	Verified fax numbers and then faxed information on transported to patients back to RNs/MDs	All faxes successful via fax confirmation

Data from pilot cycles.

Pilot cycle	Number of patients	Update given	Percentage
1	6	6	100%
2	22	19	86%
3	25	25	100%

Results (continued)

Figure 2



Discussion

•Providing verbal communication increases referral center and physician satisfaction. Physicians liked having the ability to ask follow up questions, learn from follow up reports about subsequent steps in care, and utilize the information learned to improve the care of subsequent patients. Faxing of information to the referral facility also allows nursing staff and physicians to receive information simultaneously.

•More frequent and improved communication is anticipated to result in continued or increased referrals and transports to VMC

•Learning opportunities about internal team communication arouse in this process. More frequent check-in meetings with the team are needed to insure tasks are complete and not dependent on a single person. Tracking systems of transport needed updating. Feedback from internal and external sources identified potential barriers to communication that will lead to changes in other processes, i.e. referral phone system

•In retrospect, contacting physician relations at VMC, a unit with vast experience in communications between facilities would have been beneficial earlier in the project.

•Future directions to include utilization of NICU fellows, and expansion to other pediatric areas

Conclusion

An intervention to provide updated information on transferred patients to referral physicians is feasible. Interventions are not likely to be sustainable if buy in is not obtained or other providers are not involved. More formal surveys of providers can provide evidence based support for these efforts.

References

1. Standardizing Communication from Acute Care Providers to Primary Care Providers on Critically ill Adults. Ellis, K. A., Connolly, A., Hosseinnezhad, A., and Lilly, C.M. AJCC. 2015; 24:6 496-500.