Communication Between Hospital Allied Health And Primary Care Practitioners: A Collaborative Approach to Improving Hospital Discharge Summaries

TQA 7.0

Quality Improvement Project

BACKGROUND

•This Process Improvement (PI) project provides for a standardized, best practice approach to handover communication through a smart phrase discharge summary template by hospitalists for discharging patients to primary care providers. Improved communication will ensure optimal post-hospital care planning.

•No standardized communication in the discharge summary of the necessary follow-up actions required in the post-acute care of the patient.

•Two key care coordination challenges between hospitalists and primary care providers:

*Lack of information feedback loops.

* Not having valuable information in hospital discharge summaries (Jones, C.D., et al, 2015). This lack of information and documentation presents an elevated risk of gaps in care and re-admissions.

BEST PRACTICE:

A. Defined process to clearly communicate and document necessary follow-up care needs of patients discharging from the hospital.

B. The patient's discharge summary is completed by the hospitalist at discharge, and the existing standardized templated smart phrase, named .fammeddc, is suboptimal and lacks a section dedicated to ensuring follow-up care plan items are documented.

PROJECT AIM

•PI project period was November 1, 2023 through May 30, 2024.

•PI team collaborated with ECU Health Medical Center Hospitalists, ECU Internal and Family Medicine Primary Care.

1. Develop a standardized discharge planning summary smart phrase for use by ECU Health Medical Center Hospitalist team based on ECU Family Medicine model smart phrase.
2. Education to 100% of hospitalist care team on standardized smart phrase.
3. Achieve minimum of 60% compliance with utilization of identified discharge summary smart phrase within the EMR.
4. Improved satisfaction of discharge summary quality with providers and SNF admission teams by 10% (survey results).

PROJECT DESIGN/STRATEGY

•Setting for PI project was a 991-bed Magnet designated academic trauma center which is integrated within a nine-hospital healthcare system serving 29 counties in rural eastern North Carolina and two Primary Care clinics serving the same geographical area.

•Project team reviewed the current discharge summary processes and smart phrase utilized within a discharge summary and developed revisions.

A standardized discharge summary smart phrase to be utilized for the project, was named .emcdc. The project team reviewed data and determined the need to verify accessibility to existing discharge summary template to all hospitalist providers. Baseline data of utilization of existing smart phrases was assessed to determine the most appropriate foundational smart phrase to revise.

Several Plan Do Study Act (PDSA) cycles were completed throughout the project and actions steps during each cycle were developed and implemented. Action steps included working with IT for revisions to the smart phrase, providing education to providers with initiating and receiving the discharge summaries and developing and administering a survey to providers for feedback pre, mid-point and post-process improvement. A minimum of monthly data review was completed.

CHANGES MADE (PDSA CYCLES)

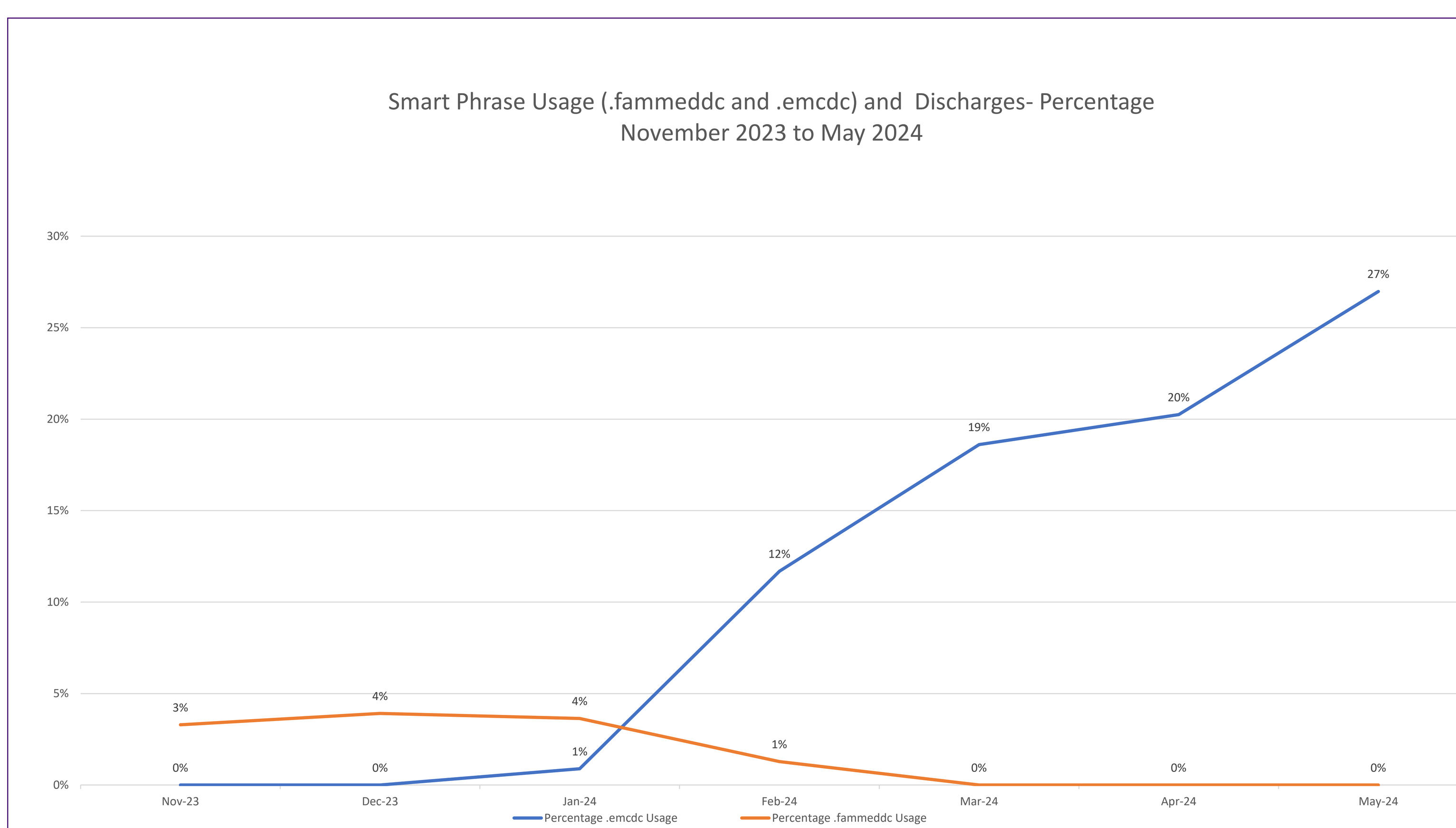

Chart 1: Utilization Smart Phrases

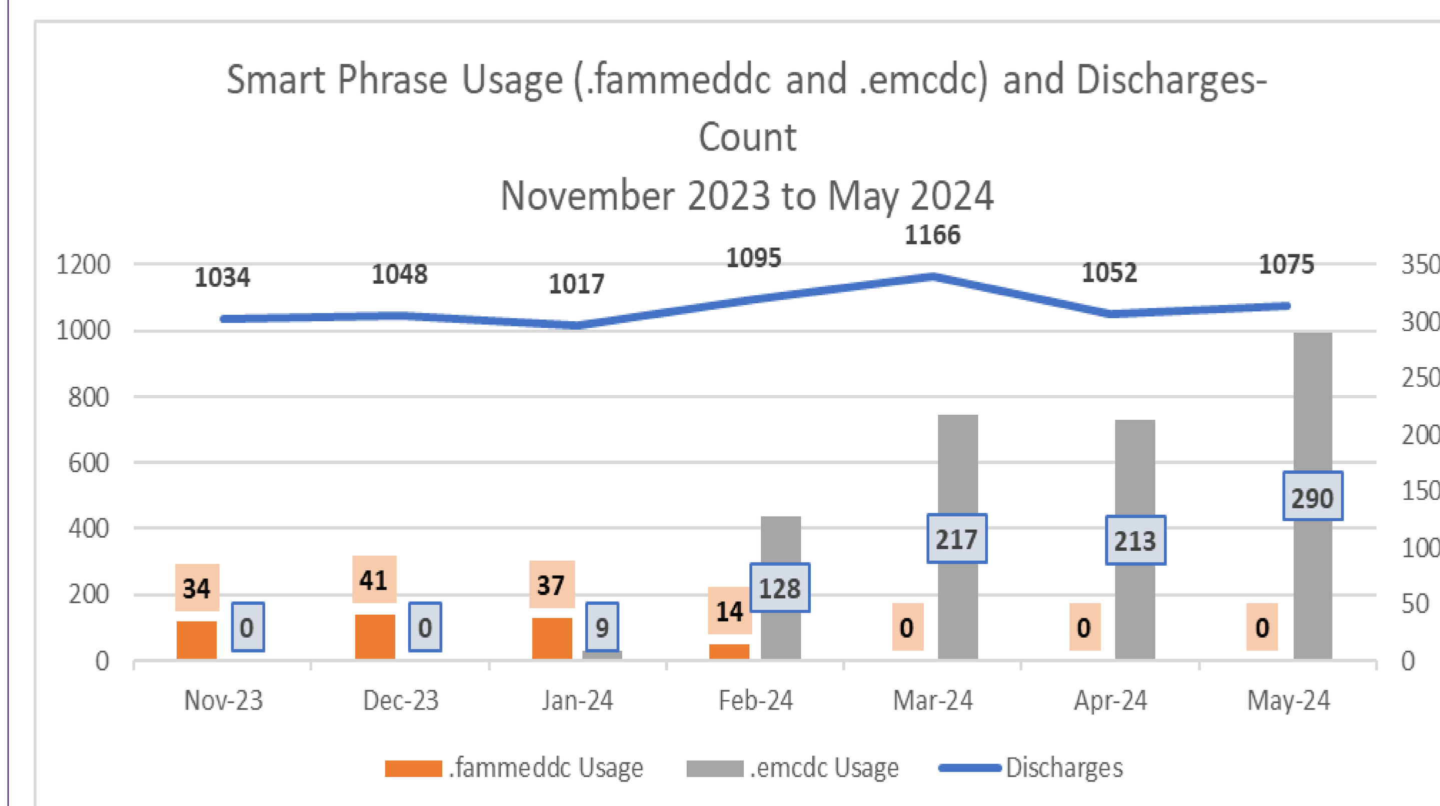

Chart 2: Smart Phrase Usage with Discharge Volumes

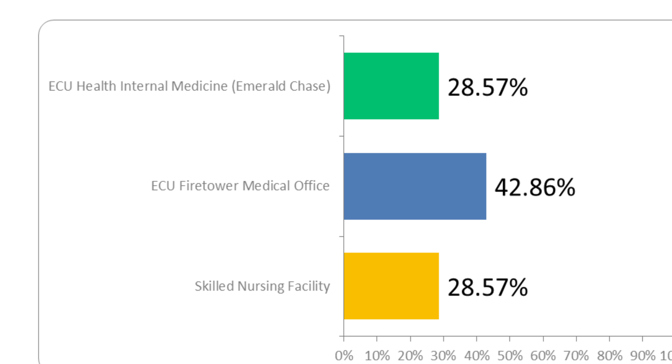

Chart 3: Initial Engagement Survey Participation

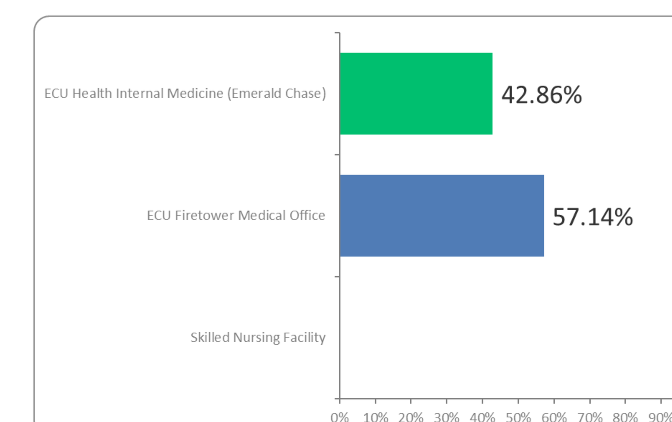

Chart 4: Mid-Point Engagement Survey

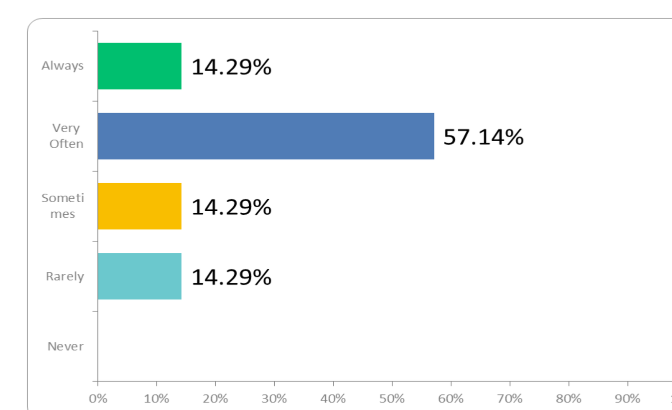

Chart 5: Recommendations for follow-up care included in discharge summary – Initial survey.

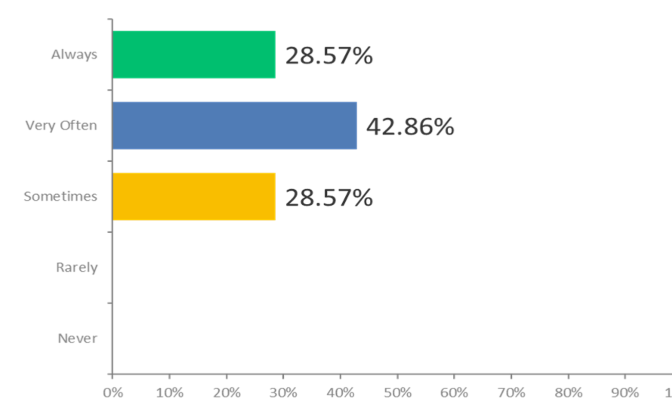

Chart 6: Recommendations for follow-up care included in discharge summary – midpoint survey.

RESULTS/OUTCOMES

•Throughout the study, project team met regularly, applying PDSA processes and review opportunities for improvement. Counts and percentages were obtained via internal databases within the EMR. Six PDSA cycles were completed during the project time. During PDSA cycle two, the project team reviewed data and found most of the hospitalists did not have access to the appropriate smart phrase for discharge. Action steps were identified and included postponing the mid-point satisfaction survey, re-education for hospitalists and development of an education tipsheet to share. The next PDSA Cycle was performed 4 weeks later, and data evidenced a consistent number of discharges with minimal use of the smart phrase. Each PDSA cycle was a continuous review of data, analysis, and assessment for necessary strategies for improvement in the process.

•At the conclusion of the PI project, the objective outcomes were reviewed. Objective number 1 was 100% of hospitalist staff completed education/training for use of identified discharge summary smart phrase. This objective was completed via in person educational sessions, email correspondence and education tipsheets. To meet the object of 100% compliance with provider education there were multiple sessions and venues of education offered. **This objective was met.**

•Objective number 2 was achievement of a minimum of 60% compliance (stretch goal 75%) with use of standardized discharge summary smart phrase (.emcdc) for all discharges by ECU Health Medical Center Hospitalist providers. **This objective was not met.** However, there was a steady increase in use of the standardized smart phrase.

•Objective number 3 was improvement of provider and SNF staff satisfaction with discharge planning by 10%. Participation in the initial survey and mid-point survey was minimal. A repeat survey was sent to participating clinic providers as well as the SNF at mid-point of the study. Participation in the survey dropped overall. **No feedback received from the SNF. Increased participation from the clinic providers.**

•Goal of the survey - to gain feedback on the inclusion of discharge planning goals with the new standardized template for discharge summary. A standard Likert scale was utilized for the survey. By half-way through the PI, the clinic providers felt the discharge summary care recommendations were being included more with utilization of the smart phrase within the discharge summary. **85.72% of providers** chose always, very often or sometimes.

•By mid-point of the PI, **100% of the providers** felt the post-discharge summary care recommendations were always, very often or sometimes included. There was no post-survey completed.

DISCUSSION/LESSONS LEARNED

•In this PI study, two implications for enhancing communication were identified.

1. Standardization of a discharge summary that includes a distinct section for identification of follow-up care planning items can be achieved through education and collaboration between hospitalists and primary care providers.
2. With continued education and support to both teams, the utilization of a standardized tool can increase.

- Limitation - few project sites that were included which rendered low volume of data.
- Strength of this study - the support and expertise from the project team and ancillary IS team members who complimented the data extraction and assisted with analyzing the outcomes.

Future steps:

1. Expansion of study to include hospitalists across the healthcare system and more primary care providers.
2. Gain more feedback from our post-acute partners at SNF would potentially enhance the quality of the discharge summaries as we work together along the continuum of care.

CONCLUSION/NEXT STEPS

•Standardization of the discharge planning summary to include a dedicated focus on post-acute follow-up plan of care tasks can be achieved with support of a multidisciplinary team.

•Standardizing the discharge planning template allows for improved inclusion of the action items necessary for the primary care provider to continue the patient care efficiently.

•Continued follow-up bi-annually with the hospitalists and Internal Medicine will be performed, and adjustments can be made to continue improvement and awareness.

ACKNOWLEDGEMENTS

The PI team would like to acknowledge Marsha Becker, Clinical Informaticist, who supported the PI team with data extraction.

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