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Improving Discharge Communication with Outpatient Providers on the Hospitalist Service

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Handoffs are crucial to transitions of care. Inadequate handoffs increase the risk of medical error, cost, and patient harm. At our institution, a standard for safe handoffs between pediatric hospitals (PHM) and primary care providers (PCP) did not exist.

**Objective**

**Aim:** To increase two-way discharge communication between PHMs and PCPs for high-risk patients from 7% to >80% within 18 months.

**Methods**

**Outcome Measure:** Two-way discharge communication

**Process Measure:** Any attempt to contact the PCP

**Balancing Measure:** PHM satisfaction with process

**Key Drivers:**
1. Efficient and standardized processes
2. Provider engagement
3. Early identification of high-risk patients

*‘High-risk’ defined as ≥1 of the following:
1. Complex chronic condition
2. Unplanned operating room visit
3. Unplanned intensive care unit stay
4. New medical equipment prescribed
5. New clinic referral unrelated to discharge diagnosis
6. Identified as a ‘patient at risk’ by social work
7. Outbound transfer

**Results**

- 1883 patients (432 baseline, 1451 implementation)
  - Outcome measure improved from 7% to 41% (Fig 1)
    - Increase from 1.7 to 10.3 communications per week
  - Process measure improved from 13% to 57% (Fig 2)
    - Increase from 3.3 to 14.3 attempts per week
  - Balancing measure increased from 5% to 35%

**Discussion/Conclusion**

- Marked improvement in two-way discharge communication for high-risk patients
- Work is ongoing in an effort to achieve our aim

**Successes:**
1. Bringing awareness to a performance gap
2. Identifying high-risk patients early
3. Utilizing support staff to coordinate discharge communication
4. Providing individual feedback to physicians

**Barriers:**
1. Ability to reach the PCP
2. Time required for two-way communication

**Future Work:**
1. Improving PHM’s ability to reach the PCP
2. Utilizing HIPAA compliant technology to streamline communication

**Contact Information**

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