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Increasing frequency of discharge communication between primary care physicians and resident teams after hospital admission for high risk patients: an improvement project in a large pediatric hospital

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Quality Improvement Abstract Title

Submitting/Presenting Author (must be a trainee): Kelsey Clary and Lyndsey Hultman
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Fellow

Primary Mentor (one name only): Nicholas Clark

Other authors/contributors involved in project:

IRB Number (if applicable): STUDY00000993

Describe role of Submitting/Presenting Trainee in this project (limit 150 words):
Resident role was to design and implement interventions with the support and guidance of their mentor and analyze results prior to implanting additional interventions.

Problem Statement/Question, Background/Project Intent (Aim Statement), Methods (include PDSA cycles), Results, Conclusions limited to 500 words

Problem Statement/Question: Increasing frequency of discharge communication between primary care physicians and resident teams after hospital admission for high risk patients: an improvement project in a large pediatric hospital

Background/Project Intent (Aim Statement): Previous study has revealed that primary care physicians desire communication with the inpatient team responsible for their patients' care and that inpatient teams consider this communication valuable. There is evidence that such communication improves transition to outpatient care and decreases readmission rate. A group of patients potentially at high-risk for poor outcomes during this transition has been defined. At our institution, discharge communication between general pediatrics resident teams and primary care physicians occurs in about 1% of admissions of high-risk patients.

Methods (include PDSA cycles): The Plan Do Study Act method of quality improvement was used to attempt to increase the frequency of discharge communication after hospital admission of high-risk patients. High-risk patients were defined as those who have a complex chronic medical condition, an unplanned ICU stay or OR visit, a "patient at risk" form completed by social work, new durable medical equipment prescribed, a subspecialty clinic referral unrelated to a discharge diagnosis, or an outbound transfer such as to another hospital or to inpatient psychiatry. Data were gathered weekly from the electronic medical record to evaluate how many high-risk patients were discharged from general pediatrics resident teams, and in those cases, how frequently discharge

communication with the primary care physician was documented. Our primary aim was to increase two-way discharge communication between resident general pediatric teams and the primary care provider for high-risk patients to 50% by January 31, 2020. Our outcome measure was two-way communication achieved, and our process measure was attempts to contact the primary care provider. Initially, education was provided to the residents, their attendings, and the team managers regarding which patients were considered high risk and how to document their discharge communication in the electronic medical record. In the current PDSA cycle, a visual reminder in the form of a list on which to track which patients are waiting on discharge communication and to track completion was securely posted in each of the resident work rooms. During this intervention, senior residents are privately reminded weekly of their team's performance in discharge communication.

Results: Initial interventions resulted in only a small improvement in frequency of discharge communication to about 5%. Our process measure remained stable at around 1% for both before and after the intervention.

Conclusions: By implementing stepwise interventions, this hospital was able to increase the frequency of discharge communication between resident teams and primary care physicians after admission of high-risk patients, although continued improvement is needed. Subsequent interventions are currently under investigation for improvement in communication rate. Small, fairly energy efficient interventions were implemented and produced modest improvement. Continued data collection will reveal whether these improvements will be sustained. Concerns about resistance from busy residents and the lack of a single person who could spend a significant amount of time organizing these efforts were barriers to the institution of some possible interventions.