Changing the Standard:
Targeting Discharge Summary Content Improvement Through Application of Standard Work.

Tulane Internal Medicine
Elliott Firm Quality Improvement Project
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Project Title: **Changing the Standard: Targeting D/C Summary Content Improvement Through Application of Standard Work.**

Aim:

Standardizing D/C summary content to include PCP name, basic information, and follow-up appointment through resident education, template changes, and addressing work flow barriers should improve throughput of information to D/C summary and may affect hospital recidivism.

Metric:

Approximately 120 patient charts reviewed retrospectively for a period of 8 weeks from 10/12-12/12 on patients admitted to yellow firm medicine teams at Tulane Medical Center.

Thirty patients represented a control group without knowingness of planned intervention and remaining 90 patients represent application of continually refined interventions as determined by PDSA methodology after soliciting feedback by the intervention resident groups.

Availability of: 1. PCP Name, 2. PCP Contact Info, and 3. Appointment date/time on the D/C summary were all tracked and readmission rates for 6-months post-intervention of the groups were measured.

Table 1: Pre-Intervention Metric Value(s):

	PCP	PCP Info	Appt	Readmit
Pre-intervention	53%	45%	40%	N/A

Intervention:

1. **Resident education for inclusion of above information on the discharge summary.**
2. **Resident education and template provided for inclusion of above information on the discharge summary.**
3. **Resident education, template provided, and effort to obtain above information at point of admission for inclusion of information on the discharge summary,**

Table 2: Post-Intervention Metric Value(s):

	PCP	PCP Info	Appt	Readmit
Intervention 1	64%	61%	53%	32%
Intervention 2	67%	61%	52%	35%
Intervention 3	84%	74%	58%	39%

Problems Encountered:

Multiple barriers were indentified in obtaining the information of the PCP provider. A number of times patients did not know their PCP or have information—simplistic items such as inappropriately identifying physician names—which made information obtainment by the team overly cumbersome.

As such, an effort was made to first educate and then to formulate a template for the residents to obtain specific primary care (or other outside provider) information. These items represent interventions 1 and 2, respectively. While these interventions did result in increase throughput of the desire information appearing on the medical record, resident feedback was that information obtainment was often difficult, time consuming, and an "afterthought" at the time of discharge and dictation of the discharge document. Hence, intervention 3 was initiated with targeting the temporal aspect of information collection—promoting that PCP identification and information gathering occur as soon as the point of admission. Throughput of the information markedly increased with this intervention.

However, the breadth of information needed to be collected was again identified as a time-consuming issue, often resulting in "google searching" providers names and information with residents' feedback suggesting if a database were available of local providers that this work would be more efficient.

It was originally assumed that PCP and PCP contact info – address, phone, fax, and email – was not available to the dictationist and other personnel in medical records. However this was in error as our research revealed that a large database of local physicians and their respective contact information DID ALREADY EXIST. Having this database available further mitigated the need for the aforementioned "google search" and limited time committed to this information collection.

When a PCP was correctly identified by the dictating resident, the dictationist could be directed on the dictation to CC the document to the PCP. With this directive, the information to appear at the end of the medical record for routing of the document to the PCP by means of mail, fax, or email by personnel of the medical records department.

The process as described above underscores the need for correct identification of PCP or other primary outside providers. Appropriate information sharing between inpatient and outpatient providers is contingent on the correct ID of the PCP. While out of scope for this project, this is an area for improvement in the future the patient and provider engagement to seek a sustainable solution.

Learning Points:

Many of the learning points are discussed in detail above.

Improvement in collection of PCP information was significant through the third intervention, and analysis reveals that obtainment of PCP name alone often resulted in increased throughput of all items of PCP information (name, contact, and appointment). On average, 51% of all tracked patients, if they had one item of the PCP information all three tracked items were present. Consistent with the findings discussed above, earlier obtainment of the information (as with intervention 3), resulted in increased throughput of all three tracked items, 61% with that subgroup.

While improvement in the inclusion of PCP information did markedly improve, it did not seem to markedly impact the rate of 6 month readmissions among the patient's tracked. While this would superficially seem to discredit the need for PCP information on the discharge summary, it was found that among the three intervention groups, on average, 45 % of those re-admitted at 6 months had

some paucity in the PCP information. And among those patients, 40%, on average, had all three items of PCP information available on the discharge summary. All had significant medical conditions with instances of ESRD, COPD, and malignancy among their chief diagnoses.

One could conclude that the recidivism to the hospital of these complex patients is impossible to avoid—but in limited occasions, there were persons who had been previously serially admitted that following our tracked intervention re-admissions stopped. In each of these instances the patients continue to be active in clinic appointments through 4/13 in the Tulane system. A result of this specific intervention, or something else?—one does not know.

Do you consider your project a success?

Yes. The interventions did improve throughput of the information to the discharge summary which was the primary point of analysis in this project. Impact on re-admission is more of mixed result—with need for continued evaluation and improvement .

Specific focus need now turn to evaluation of delivery of the medical record to outside providers and what additional interventions are needed.