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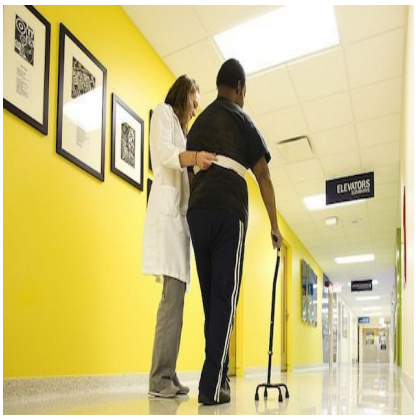
Cross-Clinic Communication in Patient Care Transitions



Guidelines to enhance communication during patient care transitions between healthcare settings have the potential to improve patient outcomes and satisfaction, as well as to decrease overall healthcare costs. During care transitions, patients' clinicians, including hospital-based clinicians and community-based primary care providers (PCPs), are responsible for sharing clinical information across settings and communicating directly, if necessary, to address time-sensitive questions and to transfer accountability for patients' care.

Despite the importance of cross-setting communication, the complex, fragmented nature of the US healthcare system leads to significant variability in the frequency, quality and effectiveness of cross-setting communication. It is increasingly rare for PCPs to follow their patients in the hospital, so hospital physicians must transfer responsibility for patient care to PCPs at hospital discharge.

This paper describes how community-wide standards, such as Rhode Island's Safe Transitions Best Practice Measures for Hospitals, as well as audit and feedback interventions, can successfully improve hospitals' communication during patient care transitions between healthcare settings.

Method

In 2009, Healthcentric Advisors, the Medicare Quality Improvement Organization (QIO) for New England, collaborated with Rhode Island healthcare providers and stakeholders to develop community-wide standards for hospitals known as the Safe Transitions Best Practice Measures for Hospitals; it then implemented a hospital quality improvement intervention. As part of this intervention, 10 of the state's 11 acute-care hospitals collected quarterly data, and Healthcentric Advisors provided audit and feedback reports showing each facility's progress and the state's average performance.

The 10 participating hospitals were allowed to freely choose when to begin reporting data for each best practice and were encouraged to begin collecting data from a single unit or floor and then to expand data collection hospital-wide over time.

Using hospital-reported data on four best practice measures and fee-for-service (FFS) Medicare claims data for Q2 2011-Q2 2013, the authors performed descriptive analyses of:

(1) Inpatient-to-outpatient communication for all patients at the 10 participating hospitals, as measured by four best practice measures, including:

- Notification of hospitalisation sent to PCPs at beginning of hospital visit;
- Hospital clinicians' contact information provided to receiving clinicians upon discharge;
- Follow-up appointment scheduled within one business day of discharge; and
- Hospital summary clinical information sent to PCPs at discharge.

(2) State-wide all-cause, 30-day readmission rates per 1,000 FFS beneficiaries. The use of a population-based measure allows the authors to account for longitudinal decreases in both admissions and readmissions.

The authors conducted the best practice analyses using Microsoft Excel (Redmond, WA) and the claims analyses using SAS v.9.2 (Cary, NC). They hypothesised that they would see increased inpatient-to-outpatient communication (as measured by the best practice process measures) and decreased hospital readmission per 1,000 beneficiaries.

Results and Discussion

From Q2 2011 to Q2 2013, hospitals' aggregate performance for the four best practice process measures increased by 5.5 percent for all patients who met eligibility criteria ($p \leq .001$ for each measure) and the readmission rate decreased by 18.4 percent from 14.12 to 11.52 per 1,000 eligible FFS Medicare beneficiaries ($p \leq .001$).

These findings suggest that community-wide standards, such as the Safe Transitions Best Practice Measures for Hospitals, and audit and feedback interventions can successfully improve hospitals' communication during patient care transitions between healthcare settings. The results show that, overall, 10 Rhode Island hospitals' communication with PCPs improved from baseline to re-measurement of the audit and feedback intervention. At the same time, Rhode Island's statewide 30-day, all-cause readmission rate for FFS Medicare patients decreased.

Although the process measure data are self-reported, the study findings are supported by the results of a recent survey administered by the Rhode Island Executive Office of Health and Human Services. Among a convenience sample of 63 PCPs surveyed electronically in November 2013, nearly eight in 10 (79.3 percent) agreed that written communication from hospitals had improved in the past three years, while fewer than half (43.9 percent) agreed that oral communication had improved in that timeframe (unpublished data). Because the best practices focus on hospitals' written (vs. oral) communication, the fact that PCPs agreed more strongly that written communication had improved appears to support the authors' belief that the increase in adherence to the process measures reflects true improvement in communication.

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