# Initiative Improved Discharge Documentation

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CHICAGO — A multimodal, multidisciplinary quality improvement process substantially improved the overall quality of discharge documents across five acute care hospitals, according to a new study by Partners HealthCare of Boston.

After the quality improvement initiative, 96% of discharge packets contained all 12 data elements required for discharge, compared with 65% at baseline.

The largest improvement was seen in documentation of preadmission medication, which rose 19% from 81% to 100%, Dr. Esteban Gandara said at the annual meeting of the Society of Hospital Medicine. Documentation also significantly increased from 91% to 97% for follow-up information and from 92% to 96% for warfarin information. The increases were particularly large for these three items because they had the most room for improvement, he said.

The retrospective analysis included 3,101 discharge documentation packets for patients discharged to subacute facilities from January 2006 through September 2008. Discharge documents included discharge summaries, discharge orders, and nursing instructions and were reviewed for 50 randomly selected patients per hospital per quarter.

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Improvements were achieved at all five hospitals in the Partners HealthCare system without financial incentives to the hospitals or physicians, said Dr. Gandara, of the division of internal medicine and primary care at Brigham and Women's Hospital in Boston. The biggest motivator was that the data were reported to the chief medical officer every quarter.

The quality improvement initiative was prompted by two recent studies at his hospital that found only 70% of discharge summaries had all of the information required by the Joint Commission. Important deficits were found regarding medication reconciliation, pending test results, and anticoagulation. There was also no formal quality assurance process in place to review discharge documentation, he said.

Interventions used during the 3-year initiative included technological improvements to hospitals' discharge ordering systems to actively solicit and/or automatically import required information into discharge documents, creation of discharge templates, feedback to clinicians and their service chiefs, staff education, and documentation reviews by nurse care coordinators prior to discharge.

Some of the hospitals did not utilize all of the interventions. They were also allowed to customize their discharge template, as long as it included all necessary data, Dr. Gandara said. The 12 required elements were treatment rendered, treatment response, allergies, preadmission medications, follow-up information, physician contact information, procedures performed, discharge medications, target international normalized ratio, and warfarin indication, duration, and dose.

The smallest quality improvement was observed at a community hospital that did not use technological improvements, while the largest improvements were seen at two academic medical centers with the greatest use of information technology, he said. Community hospitals discharged 53% of the sample, and 74% of patients were from medical units.

"Multiple interventions can improve discharge documentation," Dr. Gandara said. "Different hospitals might choose different approaches.

"Education, feedback, and publicity are necessary, but you also need some high-reliability components such as IT or case manager sweeps," he added.

Dr. Gandara acknowledged that some, but not all, of the observed improvement was likely due to changes in measurement methodology and that the study design is subject to confounding. Also, the study failed to analyze the effect of the intervention on patient outcomes.

The investigators disclosed no relevant conflicts of interest. ■

# Rapid Response Team 'Acts as a Safety Valve,' Uncovers Problems

CHICAGO — The effect of rapid response teams on hard clinical outcomes remains unclear, but such teams do seem to have an important role at many hospitals, experts said at the annual meeting of the Society of Hospital Medicine.

At the University of California at San Francisco, the rapid response team (RRT) was hospitalist-led from 2005 to 2007, but it struggled with low utilization and had little effect, said Dr. Sumant Ranji, of the university's division of hospital medicine. The RRT was disbanded, but it came back in late 2007, this time staffed by critical care nurses and respiratory therapists. Today, the RRT is popular among nurses, serves as an important liaison between floors and the ICU, and has a major role in educating new nurses.

Available 24/7, 365 days a year, the RRT responds to emergencies, follows up on ICU discharges, and proactively rounds on the wards. In about 20% of cases, the patient is transferred to the ICU.

"What we've found is that the rapid response team acts as a safety valve" and provides a way to identify system problems such as inadequate bedside staffing, poor communication between staff, and staff with inadequate training or experience, Dr. Ranji said.

An RRT should not be used as a replacement for Code Blue, said copresenter Dr. Winthrop Whitcomb, a hospitalist at Mercy Medical Center in Springfield, Mass., and cofounder of the Society of Hospital Medicine. Led by critical care nurses, Mercy's RRT is called when there is an acute change in heart rate, respiratory rate, or oxygen saturation; an acute or symptomatic change in systolic blood pressure; significant bleeding; new or prolonged seizures; unresolved chest pain; or other concerns.

After educating staff in early 2005, Mercy rolled out the RRT to all inpatient units and expanded the team to cover the entire hospital after just 7 months. The RRT includes nurses, ICU nurses, respiratory therapists, nursing supervisors, a hospitalist at night, and an intensivist during the day.

Despite receiving written educational materials about seeking assistance, after 12 months, not a single patient or family had called a rapid response at Mercy, he said.

Two other obstacles are criticism of staff members for calling the RRT and failure to have a plan for post-RRT care. A hospitalist involved in an RRT encounter must hand off care to the attending physician of record, Dr. Whitcomb said.

Billing for an RRT encounter can include critical care codes, if the encounter qualifies, or subsequent care codes, if the bill denotes a new diagnosis or an exacerbation of an existing one.

Mercy handles about a dozen rapid response calls per month, with two-thirds originating outside the ICU. A review of 449 RRT encounters showed that 45% of patients remained in their room, while 18% were transferred to the ICU. Unadjusted mortality rates for 2004-2008 were "pretty flat" at about 2.5%-3%, Dr. Whitcomb said.

In a systematic review of 13 RRT studies, Dr. Ranji and his associates reported reductions in inpatient mortality and cardiac arrest rates in 11 before-and-after studies. In the lone randomized controlled trial, however, mortality declined in the control group to a similar extent as in the observational studies (J. Hosp. Med. 2007;2:422-32).

The authors had no conflicts of interest. ■

# *Hospitalists Have Room to Improve Communication*

CHICAGO — Hospitalists could do more to improve communication with their patients, a survey of 420 hospitalized patients suggests.

The proportion of "excellent" ratings for 21 individual hospitalists evaluated using the Communication Assessment Tool (CAT) ranged from 38.5% to 73.5%, with an average of 58.8%, Darlene Ferranti and her associates reported in a poster at the annual meeting of the Society of Hospital Medicine.

For individual items included in the previously validated CAT, the highest ratings for the group as a whole were for treating the patient with respect (68%), talking in terms the patient could understand (65%), and letting the patient talk without interruption (65%). The lowest ratings were for involving the patient in decisions as much as he or she wanted (53%) and encouraging the patient to ask questions (50%).

"A significant proportion of hospitalists in this sample may benefit from targeted training to improve communication with patients, particularly in the areas of encouraging patients to ask questions and involving patients in decision making," they wrote.

The patients, who were hospitalized on general medicine inpatient units of an urban, academic hospital, were eligible to participate in the study after they had been assigned to a hospitalist for 2-3 days. Overall, 26% of patients were aged 44 years or younger, 39% were 45-64 years, and 35% were 65 years or older.

The survey included 20 patients for each of the 21 hospitalists. The hospitalists ranged in age from 30 to 36 years, and 57% were women. They had an average of 2.8 years of experience practicing as a hospitalist (range 1-8 years).

Differences between hospitalists' scores may be partly explained by specialization in a particular service, according to Ms. Ferranti, research study programs coordinator at Northwestern University Feinberg School of Medicine in Chicago, and her associates. These effects were minimized by capturing patients from different services and on different units, when possible.

The 15 items on the CAT describe performance in key aspects of effective communication, but do not reflect the particular skills and content used in successful patient-physician interactions.

"Future work could identify specific techniques used in medical interviews by highly rated physicians, with the goal of developing tools for targeted improvement," they wrote. ■