Improving physician communication during patient hospitalizations

Background

Suboptimal or delayed communication between hospital and community physicians, and between physicians and patients, can lead to serious and costly problems after patient hospitalizations, including adverse events and hospital readmissions. Timely and consistent communications among physicians during patient hospitalizations and in the post-discharge period are essential to the provision of safe, high-quality and personalized care.

Evidence suggests widespread deficits in communication at the time of discharge between physicians overseeing hospital care and community physicians. Many errors and adverse events during this time period are the result of communication failures, with the majority of post-discharge problems related to medications. Deficits in communication between physicians and patients and those persons who will be caring for patients post-discharge also contribute to suboptimal care transitions.

The SafeMed care transitions model is one of several quality improvement programs that have demonstrated reductions in hospital readmissions by improving discharge processes. As part of its *STEPS Forward*™ initiative, the AMA developed a module for implementing the SafeMed model, which uses intensive medication reconciliation, home visits and telephone follow-up to manage high-risk/high-needs patients as they transition from the hospital to outpatient setting.

Additionally, the AMA continues to engage in extensive advocacy to improve electronic health records (EHRs) and address technology barriers that impede the exchange of meaningful patient information during care transitions. Improved EHR capabilities, which will enable more widespread use of direct messaging (e.g., admit/discharge/transfer messaging) and standardized electronic forms (e.g., the Continuity of Care Document), have the potential to enhance communication among providers across multiple care settings in the future.

Communication during hospital admissions

Community physicians who are aware of their patients' hospitalizations are better prepared to provide thorough and appropriate post-discharge follow-up care. The AMA advocates that hospital admissions processes should include:

- A determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician;
- Prompt notification of actively treating physicians of the patient's hospitalization and the reason for inpatient admission or observation status;
- Timely communication of the patient's medical history and relevant clinical information by the patient's community physician(s) to the hospital-based physician;
- Notice to the patient that he/she may request admission or treatment by an actively treating physician if the physician has clinical privileges at the hospital; and
- Honoring requests by patients to be treated by their physician of choice, and allowing

community physicians to treat to the full extent of their hospital privileges.

Communication during hospital discharge

The AMA encourages initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization. Discharge summaries should be presented in a meaningful format that prominently highlights salient patient information, such as the discharging physician's narrative and recommendations for ongoing care. The AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:

- Information from patients and families/caregivers should be solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
- Patient language proficiency, literacy levels, cognitive abilities and communication impairments should be assessed during discharge planning. Particular attention should be paid to the abilities and limitations of patients and their families/caregivers.
- Specific discharge instructions should be provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions should be provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
- Key discharge instructions should be highlighted for patients to maximize compliance with the most critical orders.
- Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, should be confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
- Discharge instructions should be made available to patients in both print and electronic form, and also via online patient portals.

Medication reconciliation

The AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:

- All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken prior to the patient's hospitalization.
- An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
- Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
- For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists, should be encouraged.

For more information about Project SafeMed, visit the AMA's *STEPS Forward*™ website.