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Pediatric primary care providers' perspectives regarding hospital discharge communication: a mixed methods analysis

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Abstract

Objective—Effective communication between inpatient and outpatient providers may mitigate risks of adverse events associated with hospital discharge. However, there is an absence of pediatric literature defining effective discharge communication strategies at both freestanding children's hospitals and general hospitals. The objectives of this study were to assess associations between pediatric primary care providers' (PCPs) reported receipt of discharge communication and referral hospital type, and to describe PCPs' perspectives regarding effective discharge communication and areas for improvement.

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Methods—We administered a questionnaire to PCPs referring to sixteen pediatric hospital medicine programs nationally. Multivariable models were developed to assess associations between referral hospital type and receipt and completeness of discharge communication. Open-ended questions asked respondents to describe effective strategies and areas requiring improvement regarding discharge communication. Conventional qualitative content analysis was performed to identify emergent themes.

Results—Responses were received from 201 PCPs, representing a response rate of 63%. While there were no differences between referral hospital type and PCP-reported receipt of discharge communication (RR 1.61, 95% CI 0.97–2.67), PCPs referring to general hospitals more frequently reported completeness of discharge communication relative to those referring to freestanding children's hospitals (RR 1.78, 95% CI 1.26–2.51). Analysis of free text responses yielded four major themes: (i) structured discharge communication; (ii) direct personal communication; (iii) reliability and timeliness of communication; and (iv) communication for effective post-discharge care.

Conclusions—This study highlights potential differences in the experiences of PCPs referring to general hospitals and freestanding children's hospitals, and presents valuable contextual data for future quality improvement initiatives.

Keywords

discharge communication; medical home; children; transitions of care; collaborative

Introduction

Improving patients' and families' transitions home following hospital discharge is a national focus of research and healthcare policy.^{1–5} Although pediatric data are sparse, studies have shown that approximately one in five adult patients experience an adverse event during their hospital-to-home transition.⁶ Of these, approximately two-thirds are medication-related errors,⁶ with procedure-related injuries and errors related to pending lab results also occurring with concerning frequency.^{7–10}

Seeking to improve patients' hospital-to-home transitions, effective communication between hospital-based physicians and primary care providers (PCPs) has been established as a national standard.^{11,12} Prior studies in internal medicine have shown that direct communication between hospital-based physicians and PCPs is infrequent and inconsistent, and that discharge summaries are often unavailable at the time of the follow-up appointment.^{8,13–17} Within the pediatric literature, there is a clear gap regarding effective strategies to optimize communication between hospital-based providers and PCPs.^{7,18,19} With increasing numbers of pediatric hospital medicine programs across the United States, particularly in general hospitals, understanding PCPs' communication needs at structurally diverse hospitals is essential. Despite this, previous studies assessing PCPs' priorities and perspectives regarding discharge communication across geographically and structurally diverse pediatric hospital medicine programs are limited.^{6,18,19}

We hypothesized that pediatric-specific discharge communication systems at freestanding children's hospitals (FCH) would be associated with improved timeliness and completeness of discharge communication relative to general hospitals (GH). Employing a mixed-methods approach, we aimed to: (1) assess the associations between PCPs' referral hospital type and self-reported receipt and completeness of discharge communication and, (2) characterize PCPs' perspectives regarding effective discharge communication and areas for improvement.

Methods

Study population

The Value in Inpatient Pediatrics Transitions of Care Collaborative is a consortium of geographically and structurally diverse pediatric hospital medicine programs focused on improving the quality of patients' transitions home following hospital discharge. Each of 16 sites participating in the Collaborative recruited 20 PCPs for study inclusion, creating a total sample size of 320. Due to differences in data availability at participating sites, nine sites recruited their twenty most frequently referring PCPs while seven sites contacted five PCPs weekly over four weeks for patients discharged during the study time frame, September 2011 to January 2012. Institutional Review Board approval was obtained from each site prior to study implementation.

Study design

We distributed a questionnaire electronically to assess: (i) the value of specific data elements in discharge documents (published previously);¹⁹ (ii) current experiences regarding receipt of discharge documents; and (iii) demographic characteristics including practice type, years in practice, referral hospital, and geographic region according to United States census regions. The analysis presented here is derived from sections (ii) and (iii). Participants rated on a five-point Likert scale, (i) whether they reliably received discharge communication within two days of hospital discharge, and (ii) the completeness of this discharge communication. Responses of four or five on the five-point scale were defined as consistent receipt and completeness of discharge communication. Two open-ended questions assessed facilitators of and barriers to effective communication between hospitalists and PCPs at the time of hospital discharge: (i) "What works well about the communication you receive about pediatric inpatient hospitalization upon discharge home?" and (ii) "How could we improve the communication you receive about pediatric inpatient hospitalization upon discharge home?" We categorized referral hospitals as FCH or GH. GH were defined as hospitals that were not FCH, including both children's hospitals nested within adult academic centers and pediatric units in general community hospitals, categorized by principal investigators at each site in the Collaborative. Prior to survey implementation we pilot-tested the questions at one hospital participating in the Collaborative and revised the survey accordingly.

Analysis

We calculated descriptive statistics to summarize participants' demographic characteristics, with differences between PCPs referring to GH and FCH analyzed using Fisher's exact and chi-square tests. Modified Poisson regression²⁰ was used to assess the association between

hospital type and (i) PCP-reported consistent receipt of discharge communication within two days of hospital discharge, and (ii) PCP-reported completeness of discharge communication, controlling for geographic region, years of experience and practice type, and accounting for clustering within hospitals. Analyses were carried out using Stata13 (StataCorp 2013).

To facilitate the qualitative content analysis of responses to the open-ended questions, we uploaded responses to Dedoose, a mixed-methods data management program (Version 4.3.87 (2012) Los Angeles, CA: SocioCultural Research Consultants, LLC). The free text responses were analyzed using conventional qualitative content analysis.²¹ Three members of the study team (LB, JL, LM) reviewed all responses using a general inductive approach²² to identify concepts and to develop definitions for these concepts. Two members of the study team (LB, LM) then independently applied codes to a random sample of responses. Areas of coding disagreement were discussed with code definitions subsequently revised collaboratively, and coding repeated to ensure inter-rater agreement. The remaining responses were subsequently coded by one member of the study team (LB or LM). Related codes were then organized in categories to identify emergent themes. Upon completion of this qualitative content analysis and consistent with established mixed-methods techniques,^{23–25} the mixed-methods software enumerated frequencies of code applications according to referral hospital type.

Results

Population

Questionnaires were completed by 201 PCPs, representing a response rate of 63%. Thirteen PCPs did not identify their referral hospital and were therefore excluded from this analysis. Sixteen hospitals were represented, including 10 FCH and 6 GH (2 community and 4 nested hospitals). A total of 102 (54.3%) PCPs referred patients to a FCH, while 86 (45.7%) referred to a GH. As shown in Table 1, the majority of respondents were pediatricians, with more than half practicing at community-based practices. While characteristics of PCPs referring to FCH and GH were similar with respect to PCP specialty, practice type and years of practice, geographic region differed between the groups.

Discharge summary receipt and completion by hospital type

In unadjusted analysis, PCPs referring to GH were significantly more likely to report both consistent receipt of discharge communication within two days of hospital discharge [81% (95%CI 72–88%) vs. 58% (40%–74%)]²¹; $p=0.03$] and completeness of discharge communication [78% (95%CI 60%–90%) vs. 50% (95%CI 33%–66%)]²²; $p=0.02$] relative to PCPs referring to FCH. In our multivariable models, adjusting for the aforementioned covariates and clustering within hospitals, the difference in receipt of discharge communication was no longer statistically significant (RR 1.61, 95%CI 0.97–2.67). However, PCPs referring to GH were significantly more likely to report completeness of discharge communication than PCPs referring to FCH (RR 1.78, 95% CI 1.26–2.51).

Qualitative content analysis

168 PCPs (89.4%) responded to the open-ended questions regarding effective discharge communication and areas for improvement. Analysis yielded four major themes regarding effective discharge communication and areas for improvement: (i) structured discharge communication; (ii) direct personal communication; (iii) reliability and timeliness of discharge communication; and (iv) importance of communication to facilitate post-discharge care. Table 2 summarizes these major themes and component minor themes with representative quotes.

Similar proportions of PCPs referring to both hospital types described components of effective discharge communication, including 78 PCPs (91%) referring to GH and 90 PCPs (88.2%) referring to FCH ($p=0.64$). In contrast, 93 (91.1%) PCPs referring to FCH described areas requiring improvement, compared to 52 (60.0%) PCPs referring to GH ($p<0.001$). Figure 1 illustrates the frequencies with which respondents referring to FCH and GH discussed the major themes.

Structured Discharge Communication—Structured discharge communication in the form of discharge summaries and other discharge documents was discussed by PCPs in the context of their content, format, and mode of transmission (Table 2). Satisfaction with discharge communication content was represented by comments about pertinent and complete discharge summaries. In contrast, recommendations for improvement described two conflicting problems – insufficient or excessive detail. PCPs commented that discharge documents were lacking in detail, with specific recommendations to consistently include pertinent laboratory and radiology results, suggested changes in management, and follow up plans with PCPs and specialists. In contrast, others reported receiving too much information with recommendations to create a concise summary with clear headings. According to one PCP, “[the] discharge summary should be much more brief because information gets lost.” Another provider stated, “Frequently there is such a jumble of information that the important parts are either obscured or not present.”

With respect to the format of discharge documents, PCPs described a lack of consistency in how information was presented. One PCP stated, “I get different types and amount of info depending on which doctor is on service.” PCPs suggested use of a template or checklist to ensure that pertinent details are always included, with specific recommendations to position the chief complaint, discharge diagnosis, medication reconciliation, and pending tests requiring PCP follow up at the top of the document, and to clearly present recommended changes to the patient’s plan of care.

PCPs provided mixed perspectives about the use of fax to transmit discharge documents. Several described fax transmission as effective, complete and efficient, allowing for coordinated follow up care and uninterrupted clinic flow. In contrast, others described inefficiencies related to faxed documents, including transmission of multiple copies of the same reports, separate transmission of labs and discharge summaries, and extra lines and blank space. One PCP stated, “We often receive multiple copies of the same labs throughout the notes and lab reports so we have to fit them together to see what is duplicate and what isn’t. We sometimes get the wrong information sent over, such as parts of the chart without

the discharge information.” Concerns regarding the environmental impact of faxing was also raised, with one provider stating, “Please stop faxing it to me, you are killing trees!”

The role of EMRs in facilitating discharge communication was also discussed in terms of both its effectiveness and opportunities for improvement. PCPs who described how the EMR positively facilitated discharge communication emphasized the value of prompt and consistent access, describing EMR-generated communication as concise, accurate, and easy to read. The potential benefits of improved EMR compatibility were also described, with one provider stating “It would be great if the electronic medical records can be connected!”

Personal Discharge Communication—Personal discharge communication, defined as direct communication by phone or email tailored to specific healthcare providers and situations, was discussed by approximately one-third of respondents, with representative quotes in Table 2. Respondents described the value of “two-way communication” to ask and answer questions, to understand key details regarding the hospitalization and to address follow-up needs. PCPs described direct communication by phone as an optimal means of ensuring communication at the time of discharge, particularly for complex patients. In the words of one PCP, “I love to have phone calls on the day of discharge. We then know what to expect and can follow up appropriately... Again, nothing can replace the personal hand off by phone.” PCPs also discussed the benefits of combining a telephone call with the discharge summary, reporting that the combination of personal and structured communication ensured receipt of key information even if one of the modes of communication failed. Respondents described that they specifically appreciated attending-to-attending personal communication, discussing the value of communication from a hospitalist they know and trust. All of the PCPs who described phone calls in the context of areas requiring improvement requested that they receive telephone calls more frequently. Phone calls were described as particularly important for medically or socially complex patients and for patients with uncertain diagnoses or plans.

Email was described as an efficient means of communication, with one respondent stating, “I cannot tell you how much I appreciate a one-liner e-mail, it makes coordination of care so much easier for me and really enhances the relationships we have.” This perspective was echoed by PCPs who expressed appreciation for brief synopses via email, with more detailed structured communication to follow. Reported advantages of email communication included reliable access, with one PCP stating, “Email notifications come to me directly, so there is less concern about the message getting lost in our internal mail system.” Respondents stated that email messages improved care coordination for complicated patients, while others described favorable environmental impacts, describing email as “greener and more immediate if not at my office.”

Timeliness and Reliability—With respect to discharge communication timeliness and reliability, PCPs described benefits of receiving discharge documents within one or two days of discharge or prior to the follow-up visit, reporting how communication on the day of discharge allowed them to co-develop follow-up plans with the hospitalist and to contact families directly. However, the majority of respondents described how reliability or timeliness could be improved, particularly with respect to receipt of discharge

communication prior to the first follow-up visit. Lack of information prior to follow-up appointments was described as “embarrassing,” making the PCPs “look bad,” and prolonging wait times and visit lengths. Provision of a copy of the discharge documents to the family was suggested as a means of ensuring timely receipt of documents.

Post-discharge patient care—The fourth major theme encompassed the importance of effective discharge communication for provision of patient care, including: (i) follow-up appointments, (ii) recommended changes to management; and (iii) pending laboratory results, with representative quotes shown in Table 2. The most frequently cited positive comment about follow-up care described benefits of personal communication, such as phone calls or in-person conversations. One provider explained, “Talking directly with the discharge attending is very helpful since the discharge summaries may not emphasize the important aspects needed for appropriate outpatient follow-up.” PCPs also described their shared sense of responsibility for discharge transitions, applauding the inpatient team for communication prior to discharge and describing how this allowed PCPs to be involved in discharge planning.

The most frequent suggestion to improve patient follow-up care was clearer communication of pending labs and follow-up appointments with specialists. This was noted to be especially important for patients with complex conditions. Establishment of clear responsibility for follow-up of pending laboratory tests was raised as a specific need by PCPs, with one respondent giving an example of a near-miss on a urinary tract infection in a neonate due to poor communication of a pending lab. Other providers expressed uncertainty regarding responsibility and processes for follow-up of pending labs, stating, “I’m not always sure pending labs have been identified. I assume that if a lab was pending, the hospital somehow has a process for making sure the resident or another physician receives that result after discharge. It might be nice to have a clear statement that no lab results are pending, or... just let us in the community know that there is, indeed, a process for handling lab results that come back after discharge.”

PCPs described the importance of clearly summarizing changes in patient management, noting that this information was typically lacking in their current discharge communication experiences. The need to clearly and accurately identify the inpatient healthcare provider to contact with post-discharge questions was also described. Respondents also discussed the importance of ensuring that discharge communication was available to the provider seeing the patient in follow-up, with follow-up appointments made prior to hospital discharge suggested as a means of facilitating this.

Discussion

This multi-center study sought to characterize associations between PCPs’ referral hospital type and receipt of discharge communication, and to summarize PCPs’ perspectives regarding effective discharge communication. In contrast to our hypothesis that pediatric-tailored systems at FCH would be associated with more consistent receipt and completeness of discharge summaries, we found no significant difference between the groups with respect to receipt of discharge communication while PCPs referring to FCH less frequently

endorsed completeness of discharge communication relative to those referring to GH. While the majority of PCPs referring to both hospital types described components of effective discharge communication, PCPs referring to FCH more frequently discussed structured discharge communication, personal communication, and timeliness and reliability as areas requiring improvement.

Although previous literature describing communication systems at FCH and GH is sparse, there are several possible explanations for our findings. First, communication from pediatric hospitalists working at GH may have benefitted from systems improvements initiated by adult providers, whose focus on hospital-to-home transitions is relatively more mature. Second, the case mix at FCH may be more complex, making effective discharge communication more challenging for these hospitals.²⁶ Third, FCH may have a stronger market hold compared to GH, resulting in general hospitals working harder to satisfy referring PCPs' communication needs. Fourth, hospitalists working at GH may work with a smaller number of referring PCPs, allowing them to develop closer working relationships and personalize discharge communication with PCPs. Finally, although all but one of the sixteen sites participating in this study had residents involved in inpatient care, differences in residents' and attending physicians' discharge communication roles at FCH and CH may have contributed to our findings.

Our results, reviewed in the context of previous research, suggest several best practices for discharge communication and quality improvement initiatives at both GH and FCH (Table 3).^{8,11,12,18,19} Use of a structured discharge template to clearly and consistently present information relevant to the hospitalization and recommended follow-up plans may improve the accessibility of information to PCPs, addressing their concerns about discharge summary quality while balancing feedback about discharge summary length and content. Prior studies suggest that use of a standard template improves post-hospitalization follow-up appointment adherence¹³ and completion of recommended outpatient evaluation,^{13,14} with the same or better overall discharge summary quality.^{27,28} Our findings also highlight the impact of delayed or inconsistent discharge communication between inpatient providers and the medical home, underscoring the importance of efficient systems to transmit discharge records to PCPs prior to the first follow-up visit. Communication via EMR, when available, was frequently lauded by PCPs in this study and supports the ongoing development of efficient and accessible EMR-based discharge communication systems. If EMR are not available, a combination of faxing and providing families with a copy of the discharge record may improve the timeliness and reliability of receipt of discharge documents by PCPs.²⁹

Direct personal communication between hospitalists and PCPs is another best practice emerging from our research, aligning with previous research regarding communication between PCPs and specialists.^{30–32} These findings underscore the potential benefits of pairing the written discharge record with direct contact by telephone or secure/encrypted email. This may be particularly beneficial for patients with pending labs or other unresolved clinical problems, for those requiring timely follow-up, and for children with complex medical conditions or social situations.^{26,33}

In asking a combination of closed- and open-ended questions and applying mixed-methods analysis techniques, this research provides important contextual details regarding effective discharge communication from the perspectives of pediatric PCPs. However, our results should be interpreted in light of several limitations. First, although our response rate of 63% is well above average for surveys of physicians, response bias may influence the generalizability of our results.^{34,35} Similarly, our sample does not reflect a random sample of PCPs, which may also limit the generalizability of our results. Second, application of qualitative content analysis to analyze the free-text responses may have resulted in coding misclassification. We attempted to minimize this by following established qualitative analysis procedures to ensure consistency in code application. Related to this, unlike traditional qualitative analysis, use of an electronic survey did not allow us to probe respondents for additional details regarding their perspectives. In addition, because mixed-methods studies are specific to the particular setting or context in which the studies are conducted, conclusions may not be generalizable to the larger population.³⁶ However, we attempted to mitigate this potential limitation by sampling a large number of PCPs across a variety of geographic settings and practice environments. Lastly, we acknowledge the underrepresentation of GH in the West and of FCH in the Northeast in our sample, which influences the generalizability of our results.

Conclusion

This research summarizes the perspectives of a diverse sample of pediatric PCPs regarding facilitators of and barriers to effective communication between inpatient and outpatient providers. Our results, reviewed in the context of the broader transitions of care literature, suggest several best practices for discharge communication between inpatient providers and PCPs at the time of hospital discharge. Future studies at both FCH and GH are needed to ascertain the impact of implementing these best practices for discharge communication on patient and physician satisfaction as well as patient-level outcomes.

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Abbreviations

EMR	Electronic Medical Record
PCP	Primary care provider
FCH	freestanding children's hospital
GH	general hospital

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What's new?

This study describes primary care providers' perspectives about effective discharge communication and areas for improvement between inpatient and outpatient providers at freestanding children's hospitals and general hospitals, providing valuable data to inform best practices and quality improvement initiatives.

Figure 1.
Frequency of code application for major themes according to referral hospital type.

Table 1

Characteristics of primary care provider respondents.

Demographic characteristics	Referral hospital type		p-value
	Freestanding Children's hospitals (N=102) n (%)	General hospitals (N=86) n (%)	
PCP specialty			
Pediatrician	94 (94.0)	75 (88.2)	0.17
Family Practice Physician	5 (5.0)	5 (5.9)	
Physician's Assistant or Nurse Practitioner	1 (1.0)	5 (5.9)	
PCP Practice type			
Private practice	66 (65.4)	50 (59.2)	0.68
Government Clinic	5 (5.0)	4 (4.8)	
Hospital Based Group	30 (29.7)	30 (35.7)	
Years in practice			
0–5 years	20 (20.0)	6 (7.1)	0.05
6–10 years	14 (14.0)	19 (22.4)	
11–15 years	25 (25.0)	20 (23.5)	
> 15 years	41 (41.0)	40 (47.1)	
Referral hospital geographic region			
West	47 (46.5)	0 (0)	<0.001
Midwest	28 (27.7)	13 (15.5)	
South	17 (16.8)	12 (14.3)	
Northeast	9 (8.9)	59 (70.2)	

Table 2

Thematic areas and representative quotes from primary care providers in response to open-ended questions about what works well and areas for improvement regarding communication from hospitalists at the time of discharge.

Representative quotes	
Positive feedback	Areas for improvement
<i>Major theme: Structured discharge communication. Minor theme: Content</i>	
<p>"If it is a bread and butter admit, the discharge summary can be simple. However, if patient is more complicated more detail is warranted and is usually provided."</p> <p>"I am made aware of what, if anything, I need to follow up on and the reason they were hospitalized"</p>	<p>"...No extra information such as insurance info, hospital info, room number, etc. There is always lots of garbaley-goop that I have to sift through to find the pertinent info."</p> <p>"The information faxed over for each hospitalization is often too much. We receive daily progress notes and it is very hard to follow the flow of the hospitalization. It would be good to get the admit note and the discharge note with labs and relevant studies done and pending and meds/consults ordered..."</p>
<i>Major theme: Structured discharge communication. Minor theme: Format</i>	
<p>"I like that they call and give the brief explanation with a sign-out style phone call. All the nitty-gritty details are found in the written discharge summary that is faxed to me."</p>	<p>"I usually receive a multi-page fax that is formatted for a computer, but not ready for human consumption..."</p> <p>"Essentials of hospital stay are usually present, although sometimes challenging to piece together from the summary provided."</p> <p>"...There are too many sheets with too little information on each sheet...."</p>
<i>Major theme: Structured discharge communication. Minor theme: Mode of communication</i>	
<p>"The best way to communicate with me is through[EMR]. Sending staff messages through [EMR] and cc'ing discharge summaries in a timely manner works well."</p>	<p>"The fax that you send is not bad, but can be inconsistent... I would probably appreciate an EMR message more than other email because I can quickly move from that message to immediate scheduling action."</p>
<i>Major theme: Personal discharge communication. Minor theme:Phone</i>	
<p>"I have received personal phone calls on my cell phone from the attending. This is far preferred to relying on a dictation from a resident, which is often either in error or insufficiently thorough."</p> <p>"I also receive excellent verbal communications by phone with updates while patients are in-house, which is very helpful for my continuity of care."</p>	<p>"I like when the attending calls, rarely we have a medical student or resident who calls to update us about a patient and sometimes there are gaps in the information we receive from those sources."</p> <p>"For me personally, it would be helpful to be called on the first day of a patient's admission by the attending physician, and then intermittently during the hospital stay if there are significant issues and to arrange discharge planning is essential."</p>
<i>Major theme: Personal discharge communication. Minor theme:Email</i>	
<p>"I used to get emails from some of the hospitalists just notifying me of the discharge and giving a synopsis, which was nice and time efficient also."</p>	<p>"Often I see a patient of one of my partners. The discharge communication (almost always an email) goes to my partner, and I have no way to access that info in an efficient manner."</p>
<i>Major theme: Timeliness & reliability. Minor theme: Timeliness</i>	
<p>"The pediatric clinic utilizes the timely discharge information to contact the family within 48 hours of receiving the information. Helps with transition of care."</p> <p>"Receiving the discharge paperwork prior to the patient's follow-up in outpatient clinic is important, as well as, information (ie lab results) to assist in follow-up decisions."</p> <p>"When I am notified initially regarding the admission this works the best. I am usually proactive about reviewing the medical record every few days to keep myself abreast of changes, as well as visiting with the family."</p>	<p>"...without the discharge summary and pertinent information regarding the hospitalization, the follow up visit is quite difficult and very nonproductive. The discharging physician/facility is the one that looks bad and harbors much blame from the family as it seriously complicates the follow up visit to have to track the information down. It prolongs the wait time/visit time for that patient and everyone scheduled thereafter..."</p>
<i>Major theme: Timeliness & reliability. Minor theme: Reliability</i>	
<p>"The hospital and my office use the same electronic medical record so I can access all the information I need promptly."</p>	<p>"When I get a call about discharge or get paperwork faxed or electronically, it is thorough and sufficient. But I do not always get this info before I see patient or in a timely manner. Embarrassing and incomplete to have to ask the patient/family."</p> <p>"...Too often I see documented in the attending note "PMD made aware of patient's admission and updated on course" or something to that effect, because in rounds an attending told an intern to do so--and it often slips through the cracks. I believe PMD</p>

Representative quotes	
Positive feedback	Areas for improvement
	<p><i>notification should be on an attending to attending basis so that information can be concisely communicated and questions can be asked...</i> "</p> <p><i>"We sometimes don't get d/c summaries, and I think it is because our clinic is not identified as the PCP..."</i> "</p>
<i>Major theme: Post-discharge patient care. Minor theme: Patient follow-up</i>	
<i>"When it occurs, communication is very helpful toward ongoing care of the patient."</i>	<i>"...I do think making the PCP part of the follow-up plan before discharge when there are action items left that included having the patient seen after discharge, pending labs, is critical for continuity of care. If this can occur while the patient is still in-patient, that would be invaluable."</i>
<i>Major theme: Post-discharge patient care. Minor theme: Pending labs</i>	
<i>"I find that the phone call is helpful especially if there are labs or studies that need to be followed up on."</i>	<p><i>"For patients where there is further work up, pending laboratory studies, or specialist visits scheduled, this information should be clear..."</i></p> <p><i>"...a greater explanation if changes to a current plan are made, as well as which specialists consulted on the pt while they were in the hospital."</i></p> <p><i>"...I often feel that my opinion as an outpatient physician is not relevant or valued by the inpatient team and any management plans that are in effect are ignored. My only value seems to be to make the outpatient appointment..."</i></p>

Table 3

Best practices for discharge communication between inpatient and outpatient providers.

1	Use a structured discharge template to clearly and consistently present information relevant to the hospitalization and recommended follow-up care.
2	Format discharge summaries to first emphasize essential information and to minimize duplication.
3	Use both structured and personal communication, especially for patients who are socially or medically complex, or who need short-term follow-up.
4	Provide discharge communication before the first follow-up visit, and preferably on the day of discharge.
5	Formalize a transparent communication process for actionable lab results that return postdischarge.