

May 2008

Dear Physician:

The Improving Physician Communications Action Team is seeking your input to better define physician preferences in receiving and exchanging information.

The Improving Physician Communications Action Team is one of six teams formed as a result of the 2007 Doylestown Physician-Hospital Summit.

As you may recall, the theme of the summit was “The Future of the Practice of Medicine in Central Bucks.” We believe improved communication among physicians is key to the success of our practices well into the future.

We have outlined some of the issues relevant to Physician Communication in the following brief paper. **Please read the paper and return the attached survey to the Medical Staff Office by June 15.**

- Doug Nadel, MD, Chairman

Action Team Members

- Larry Brilliant, MD
- Chuck Burrows, MD
- Alan Chang, MD
- Scott Levy, MD
- Mary Ellen Pelletier, MD
- Thea Semanoff, MD
- Pete Urffer, MD

Improving Physician Communication Survey

Which of the following devices do you currently use?

- pager
- text pager
- cell phone without texting
- cell with texting
- mobile e-mail (e.g. Blackberry, iPAQ)
- other _____

For the following questions, feel free to make more than one choice, but rank your answers starting with "1" to indicate your first preference. Please provide the relevant number and/or e-mail address to be listed on an updated "On Call" list.

When you are on call for the ER, how would you like to be contacted?

- pager
- cell phone
- text message
- e-mail
- call office/answering service
- other _____
- N/A

If you are not on call for the ER, but you are covering your practice, and you need to be contacted by another Physician, by a nurse caring for your patient, or by a patient with an emergency, how would you like to be contacted? Please provide the relevant number and/or e-mail address.

- pager
- cell phone
- text message
- e-mail
- call office/answering service
- other _____

Any other comments on how you wish to be contacted when necessary? Or any other suggestions for improving Physician communication at Doylestown Hospital?

Name _____

(Required. Anonymous comments are also welcome on a separate sheet.)

Please return to Medical Staff Office by June 15 by fax (215-345-2633) or interoffice

Improving Physician Communications Action Team Position Paper

May 12, 2008

Introduction

Consider the following (semi-hypothetical) case scenarios:

Scenario 1. It's 5:30 PM, you've just left the office and you're heading home when your phone rings. Dr. X wants to know when you're going to see his patient? He wrote an order for a consult yesterday and the Unit Clerk was supposed to call you.

Scenario 2. Patient C.D. was discharged to Pine Run three days ago, and now two other patients on her floor have severe, intractable diarrhea. A few weeks later the discharge summary arrives, telling the Pine Run staff what they figured out on their own a little too late. If they had known about the *C. diff*, proper isolation precautions would have been followed.

Scenario 3. The ICU Unit Clerk calls you after hours for a "STAT consult." The Clerk doesn't know any details, but if you want to hold for a moment, she'll try to find the nurse for you.

Scenario 4. A 65-year old male is treated by the Hospitalist service for chest pain. His CXR shows a lung nodule, "...compare to previous CXR, or evaluate with CT." When he is discharged, a visit with his PCP is arranged and the patient is educated about the nodule. A discharge summary is sent to the PCP. The patient misses his follow-up appointment, however, and nine months later his work up begins.

Scenario 5. A new patient is in your office, referred by Dr. Y. The patient doesn't know why she's there. "Dr. Y said he'd send you my information, you mean you don't have it?"

Miscommunication between Physicians can result in delayed diagnosis, medication errors, increased litigation risk, hospital readmission, and unnecessary testing. The impact on patient quality of care is direct and profound.

The potential for miscommunication can occur in the outpatient setting, with inpatient consultations, when care is provided in the Emergency Room, and when care is transferred to and from a Hospitalist. Each of these settings will be explored below.

Outpatient Consultations

Communication between PCPs and Specialists is often lacking in both timeliness and content. Physicians making referrals have switched hospitals and specialists because of poor communication.¹ Communication between a PCP and a Specialist flows in both directions.

A brief note or Referral Letter from a PCP to a Specialist can greatly enhance patient care. In fact, CMS requires a written note stating the reason for the consultation in order to correctly code the visit as a consult. In surveys, Specialists would like to receive the following information from the PCP in a Referral Letter:

- statement of the problem/reason for the referral
- current medications
- relevant medical history
- details the patient would be unable or unlikely to provide

PCPs find that the main barrier to creating an ideal Referral Letter is the time commitment.¹

Surveyed PCPs, in return, would like the following information in reports from Specialists:

- answers to specific questions
- assessment of the patient
- results of tests or procedures
- therapy proposed or initiated¹

PCPs often complain of excessive delays in receiving reports back from Specialists. Studies in the 1980s and 90s found that referring Physicians received timely feedback from consultants only 50-60% of the time.¹

Inpatient Consults

Our Medical Staff Bylaws clearly encourage Physician-to-Physician communication when consults are requested. According to the Department of Medicine Rules and Regulations: “consultations are requested by the Physician ordering the consultation, directly discussing the case with the consulting Physician and/or his surrogate except for completely routine or non-time sensitive consultations.” The Department of Psychiatry also requires that “the attending Physician shall speak directly with the consulted psychiatrist.”

On the receiving end, Specialists receiving Consultation requests are responsible for simplifying the process of contacting them. Making your pager or cell phone number available to other Physicians ensures that you can be reached quickly and easily.

Our Bylaws also specify that consults be performed in a timely manner: “Consultations shall be completed within twenty-four hours of the request, unless otherwise specified.” Effective May 1, 2008, all Consultation Reports must be dictated.

Emergency Room Care

For the ER staff, obtaining relevant medical information about a patient in the middle of the night can be frustrating, especially if the patient has been treated outside the Doylestown clinical network. The development of Personal Health Records would be a great boon in such a situation.

After Emergency Room Care, this information must be transferred back to the patient’s regular caregivers for appropriate follow-up. Sometime in the next year, records from an

ER visit will be easily accessible through the new Client Server, making it easy to obtain relevant information (discharge diagnoses, test results, medication changes).

Hospitalist Care

There is a significant risk of miscommunication when care is transferred between a PCP and a Hospitalist. By definition this situation creates discontinuity of care, with loss of information, confusion over responsibilities, and an increased risk of medical and legal complication.²

From a legal standpoint, the Hospitalist has a duty to the patient “until the handoff is complete,” and this includes pending tests, revised test results, and incidental findings. The PCP has a duty to the patient to obtain hospital records if they are not received.³

In published studies (from different institutions), 78% of PCPs said they desire handoff communication, and 63% said they “always or usually” received a discharge summary. Only 56% of PCPs thought the handoff was satisfactory.² The preferred mode of communication varied from doctor to doctor: telephone call, face-to-face, fax, or discharge summary.⁴ PCPs received discharge summaries before the follow-up appointment only 8-33% of the time.^{4,5,6}

JCAHO requires discharge summaries to be completed within 30 days, but this is clearly inadequate, as most patients will require follow-up within the first month after discharge. On the day of discharge, an interim discharge note should be sent to the primary care Physician by e-mail, fax, or snail mail.⁶

Vital information to communicate upon discharge includes:⁶

- Medications
- Testing (completed, pending, and planned)
- New diagnoses
- Complications
- Plans for follow-up

Technology exists to extract information into discharge summaries to ensure accuracy (*e.g.*, medication names and doses) and to facilitate rapid completion of summaries. In a trial of computer-generated discharge summaries, the omission rate for essential items decreased, and 70% of Physicians expressed a preference for this format, finding that the computer-generated summaries were shorter and clearer than dictated summaries.⁶ If possible, patients should be given a copy of the discharge summary or note and told to bring it to their follow-up visit.

Barriers to improvement include time constraints on Hospitalists and PCPs, and variability in preferred communication methods (phone, fax, e-mail). In one survey, 77% preferred telephone contact, and felt that contact on both admission and discharge was important. Only 48% felt that interruption was needed for important tests. Very few (6%) wanted daily notification.⁴

Methods of Communication

In multiple studies, telephone communication has been demonstrated to improve clinical outcomes.² Communication by Fax has the advantage of providing written documentation, but does not allow for two-way communication. Discharge summaries provide written (and legible!) documentation, but there is an inherent delay in dictating, transcribing, and transmitting the summary. In a 2002 study only 8% preferred e-mail⁴ and some reports have suggested that e-mail is less reliable than a telephone conversation.^{7,8}

Nevertheless, improvements in technology have the potential to greatly reduce miscommunication. Each method of communication has its own advantages and drawbacks.

Pagers

Once considered high technology, pagers are rapidly becoming obsolete due to the widespread use of cell phones. Since you still need to carry a phone to answer the page, why carry two devices? Newer text-based pagers allow more information to be conveyed, but the communication is still one-way.

Cell Phones

Indispensable to the Physician on call, it's hard to find anyone who doesn't use one. This is the only mode of communication that is truly "real-time," allowing an actual conversation. In many circumstances real-time is not desirable. If you are with a patient, at a restaurant, or asleep, "asynchronous" communication (such as by pager, fax, text message, or email) may be preferable, giving you a chance to finish what you're doing, move to a private location, and collect your thoughts. A cell phone does allow asynchronous communication: if you are unable to answer right away, you can reply to a voice mail a few moments later.

Text Messaging

R U IN 2 TXTING? Text Messaging offers many advantages. The communication is two-way but asynchronous, so you won't be interrupted excessively. It is easy to confirm receipt of the message. It is also quieter than a telephone conversation, and preserves confidentiality. However, for complex medical issues texting is not a suitable substitute for a direct conversation. Another disadvantage is that you can only text someone if you know his or her cell phone number.

E-mail

Mobile e-mail preserves all the advantages of text messaging, and has the added benefit of documenting your communications and (arguably) improved security. For Physicians in the Doylestown Network, you don't even need to know his or her address—everyone is automatically registered in the system. A disadvantage is that nobody wants to be interrupted every time an e-mail arrives; there are too many non-urgent messages and spam circulating.

A few suggestions for good cell phone/e-mail etiquette

- When receiving an important text message or e-mail, send a reply so the sender knows the message was received
- Don't assume an important message was received unless you receive a reply
- Don't "reply to all" unless necessary

Recommendations from the Action Team

- All Physicians on call should carry at least a cell phone.
- We encourage the use of mobile e-mail, provided free of charge by Doylestown Hospital.
- Except for the most routine situations, Physician-to-Physician communication is essential for inpatient consults.
- H&Ps, Discharge Summaries, and Consultations should be dictated as soon as possible.
- Transcription of H&Ps and Consultations should be available within 24 hours.
- For Discharge Summaries where immediate transcription is required (*e.g.*, transfer to Pine Run or another facility) use work type 7 when dictating.
- If you use an answering service, don't use them to insulate yourself from other Physicians; encourage the service to let other Physicians speak with you directly.
- Above all, treating others as you would like to be treated will improve the general culture of Physician-to-Physician communication.
- Each Physician should carefully reassess how he or she wishes to be contacted by other Physicians, nurses, and by patients with emergencies. The printed "Physician On Call" list will be updated to reflect any changes. In addition to the office telephone number, Physicians should list their pager number, cell number, or e-mail address for direct communication.
- More group practices should utilize the "Practice" side of the Physician On Call list, so the appropriate doctor on call for a practice can be easily reached even when he or she is not on ER call.

HOW 2 speak TXT

Or, how to pretend you're a teenager

While text-messaging doctors say abbreviations commonly used in medical files have made their way into text speak, a universal set of abbreviations and terms unique to text messaging includes the following popular phrases:⁹

PHRASE	MEANING
2	to, too
2day	today
2moro	tomorrow
2nite	tonight
4	for
AAM	as a matter of fact
AFAIC	as far as I'm concerned
ASAIK	as soon as I know
ATB	all the best
B	be
BCNU	be seeing you
B4	before
C	see
CUL8R	call you later
HAND	have a nice day
HTH	hope this helps
IIRC	if I recall correctly
IMHO	in my humble opinion
IOW	in other words
L8	late
LOL	lots of luck, laugh out loud
Mob	mobile
Msg	message
NE	any
NE1	anyone
NRN	no reply necessary
PCM	please call me
PPL	people
RUOK	are you OK?
THNQ	thank you
TIA	thanks in advance
TTUL	talk to you later
TUVM	thank you very much
WRT	with respect to

References

1. Gandhi TK, Sittig DF, *et al.* Communication Breakdown in the Outpatient Referral Process. *J Gen Intern Med* 2000;15, 626-631.
2. Howell, E. Transitions of Care Between Hospitalists and Office Internists How to Better the “Handoff.” Power Point Presentation, August 4th 2006, Johns Hopkins University School of Medicine/Johns Hopkins Bayview Medical Center.
3. Alpers. Key Legal Principles for Hospitalists. *Dis Mon* 2002;48(4),197-206.
4. Pantilat. Primary Care Physician Attitudes Regarding Communication with Hospitalists. *Dis Mon* 2002;48(4),218-29.
5. Van Walraven. Dissemination of Discharge Summaries: Not Reaching Follow-up Physicians. *Can Fam Physician* 2002;48,737-42.
6. Kripalani S, LeFevre F, *et al.* Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *JAMA* 2007; 297(8), 831-841.
7. Goldman. Culture Results via the Internet: a Novel Way for Communication After an Emergency Department Visit. *J Pediatr* 2005;147(2),221-6.
8. Ezenkwele. A Randomized Study of Electronic Mail Versus Telephone Follow-up After Emergency Department Visit *J Emerg Med* 2003;24(2),125-30.
9. Dolan P. R U N2 TMing? *American Medical News* February 4, 2008, pp. 13-14.