After reviewing literature, the "Epic and provider, or skilled nursing facility) admissions to a single academic medical center’s resident nationally. Transfers are high

**Introduction**

Institutional Review Board Approval #19E.157

Obtained a priori subjective resident and attending outcomes through an electronic pre

Educated residents and attendings regarding the new process electronically and in person

Created a templated note to centralize documentation (Fig. 2) that:

- Incorporates "nudges" to encourage:
  - Asking new standard-of-care questions
- Following a new intra-hospital communication checklist to advise the appropriate clinicians of pending admissions
- Educated residents and attending regarding the new process electronically and in person
- Obtained a priori subjective resident and attending outcomes through an electronic pre-post chart review
- Institutional Review Board Approval

**Methods**

After reviewing literature, the "Epic UserWeb," and seeking clinician input we:

- Established a new intra-hospital communication flow (Fig. 1)
- Created a templated note to centralize documentation (Fig. 2) that:
  - Is used by attendings while speaking with an outside clinician to capture critical clinical information
  - Sufficient Documentation on Patient Arrival
  - Incorporates "nudges" to encourage:
    - Asking new standard-of-care questions
  - Following a new intra-hospital communication checklist to advise the appropriate clinicians of pending admissions
  - Educated residents and attending regarding the new process electronically and in person
  - Obtained a priori subjective resident and attending outcomes through an electronic pre-post chart review
  - Published note post chart review
  - Patient safety
    - Improved satisfaction with the admission process:
      - 84% vs. 95% (pre/post) residents
      - 71% vs. 63% (pre/post) attendings
    - Improved sense of patient safety:
      - 63% vs. 3% (pre/post) residents
      - 66% vs. 5% (pre/post) attendings
    - Major trend toward improved documentation:
      - 0% vs. 5% (pre/post) residents
      - 0% vs. 6% (pre/post) attendings
    - Length of stay trended from 7.6 to 7.2 days

**Results**

Provider Outcomes (Fig. 3a-c):

- *49% (pre)/95% (post) residents favored implementing the process permanently across all Department of Medicine services
- None of residents and 86% of attendings favored implementing the process permanently across all Department of Medicine services
- None responded against

Patient Outcomes (Fig. 4a-c):

- *14% (pre)/12% (post) inter/intra-hospital admissions
- *66% (pre)/71% (post) post-intervention patients for whom providers followed the process were included for comparisons
- *Rapid Response Team (RRT) activation within 24 hours trended from 0.8% to 0% (post)
- *30-day readmission trended from 12% to 11.2%
- *Inpatient mortality trended from 1.4% to 0%
- *Length of stay trended from 7.6% to 7.2% days

**Conclusions**

A templated centralization of clinically-relevant outside admission information and protocolized communication process non-significantly improves clinicians’ assessment of documentation sufficiency while significantly improving clinician satisfaction and sense of patient safety. We report no significant changes in patient outcomes but note promising trends across multiple patient safety and outcome metrics that deserve further study. Our institution is currently refining the template and process for adoption across all medicine specialties. We encourage inter-institutional collaboration and lesson-sharing on this topic.

**References and Acknowledgments**

We wish to acknowledge and thank the medicine residents and hospital medicine attendings whose input, education, and feedback for this project were instrumental to its success and improving the care of the patients we jointly serve.

**Fig. 2: Refined Outside Acceptance Note Template**

**Fig. 3: Sensitivity of Satisfaction with Admission Process**

**Fig. 4: Length of Stay**

**Fig. 4a: Care Escalation within 24 Hours of Arrival**

**Fig. 4b: 30-Day Readmission and Inpatient Mortality**

**Fig. 4c: Length of Stay**

**Fig. 4d: 30-Day Readmission and Inpatient Mortality**

**Fig. 4e: Length of Stay**

**Fig. 4f: Length of Stay**

**Fig. 5: Hypothesis**, **Fig. 6: Hypothesis**, **Fig. 7: Hypothesis**, **Fig. 8: Hypothesis**, **Fig. 9: Hypothesis**, **Fig. 10: Hypothesis**

**Fig. 11: Hypothesis**, **Fig. 12: Hypothesis**, **Fig. 13: Hypothesis**, **Fig. 14: Hypothesis**, **Fig. 15: Hypothesis**, **Fig. 16: Hypothesis**

**Fig. 17: Hypothesis**, **Fig. 18: Hypothesis**, **Fig. 19: Hypothesis**, **Fig. 20: Hypothesis**, **Fig. 21: Hypothesis**, **Fig. 22: Hypothesis**

**Fig. 23: Hypothesis**, **Fig. 24: Hypothesis**, **Fig. 25: Hypothesis**, **Fig. 26: Hypothesis**, **Fig. 27: Hypothesis**, **Fig. 28: Hypothesis**

**Fig. 29: Hypothesis**, **Fig. 30: Hypothesis**, **Fig. 31: Hypothesis**, **Fig. 32: Hypothesis**, **Fig. 33: Hypothesis**, **Fig. 34: Hypothesis**

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**Fig. 41: Hypothesis**, **Fig. 42: Hypothesis**, **Fig. 43: Hypothesis**, **Fig. 44: Hypothesis**, **Fig. 45: Hypothesis**, **Fig. 46: Hypothesis**

**Fig. 47: Hypothesis**, **Fig. 48: Hypothesis**, **Fig. 49: Hypothesis**, **Fig. 50: Hypothesis**, **Fig. 51: Hypothesis**, **Fig. 52: Hypothesis**

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**Fig. 95: Hypothesis**, **Fig. 96: Hypothesis**, **Fig. 97: Hypothesis**, **Fig. 98: Hypothesis**, **Fig. 99: Hypothesis**, **Fig. 100: Hypothesis**