Key Elements and Formatting
Discharge Instructions

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Applying Research to Optimize Care®
Objectives

• Describe the key elements that should be included in inpatient discharge summaries.
• Describe formatting techniques that can improve readability for the patient.
Conditions of Participation

DATE: May 17, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning
Discharge Planning CoP

• CoP = Conditions Of Participation

• Discharge Planning Guidance Revised 5/13/2013
  – “...must have in effect a discharge planning process that applies to all patients. . . specified in writing”

• Interpretive Guidelines
  – “Hospital discharge planning...process that involves:”
    • appropriate destination
    • requirements for smooth and safe transition
ALLOW ME TO EXPLAIN THROUGH INTERPRETIVE DANCE
Discharge Planning CoP

• “While hospitals are not solely responsible for the success of their patients’ post-hospital care transitions... expected to employ a discharge planning process that improves the quality of care for patients and reduces the chances of readmission.”
4 Stage Discharge Planning Process

- **Screening** . . . risk of adverse health consequences post-discharge
- **Evaluation** . . . post-discharge needs
- **Development** . . . Discharge plan
- **Initiation** . . . Implementation of discharge plan prior to discharge

- Input from medical staff, post-acute care facilities, patients and advocacy groups
Hospitalist to PCP

- Info transfer and communication deficits at hospital discharge are common
  - Direct communication 3-20%
  - Discharge summary availability at 1st post-discharge appt 12-34%; 51-77% at 4 weeks
  - Discharge summaries often lack info
    - Dx test results (33-63%), hospital course (7-22%), discharge meds (2-40%), pending test results (65%)
    - Follow-up plans (2-43%), Counseling (90-92%)

Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW
JAMA 2007;297:831-41.
Discharge summaries are grossly inadequate at documenting both tests with pending results and appropriate f/u providers.

“Discharge summaries are grossly inadequate at documenting both tests with pending results and appropriate f/u providers.”
Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine

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Principles

- Accountability
- Responsibility
- Coordination of Care
- Family Involvement
- Communication
- Timeliness
- National standards and metrics

Consensus Principles and Standards for Managing Care Transitions

<table>
<thead>
<tr>
<th>Principle</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accountability</td>
<td>All transitions must include records that contain minimum required elements, ideal elements should also be included.**</td>
</tr>
<tr>
<td>2. Responsibility</td>
<td>At every point during care transition, patients (and their families) must know who is responsible for care and how to contact the caregiver. Transition responsibility belongs to the sending clinicians and organizations until the receiving providers confirm assumption of responsibility.</td>
</tr>
<tr>
<td>3. Coordination of care</td>
<td>As the hub of care, coordinating clinicians must provide timely communication to other care providers.</td>
</tr>
<tr>
<td>4. Family involvement</td>
<td>Patients and families must be involved in and retain ownership of transition records, including information needed to identify patients’ medical care homes and coordinating clinicians.</td>
</tr>
<tr>
<td>5. Communication</td>
<td>Clinicians or institutions must provide a clear and direct communication infrastructure, including transition records, treatment plans, and follow-up expectations.</td>
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<tr>
<td>6. Timeliness</td>
<td>Transition teams must provide information feedback and feed-forward (based on transition settings, patient circumstances, level of acuity, and transition responsibility).</td>
</tr>
<tr>
<td>7. National standards and metrics</td>
<td>Standard communication formats for care transitions should be adopted, implemented, and used for accountability and continuous quality improvement. Standardized methods of measuring outcomes should be implemented across healthcare settings.</td>
</tr>
</tbody>
</table>

**Minimum required information in the transition record:
- Principal diagnosis and problem list
- Medication list (reconciliation)
- Identification of the coordinating physician/institution and contact information
- Patient’s cognitive status
- Test results and pending test results

**Ideal information in the transition record (plus all minimum required information):
- Emergency plan and contact person, including telephone number
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, and consent
- Planned interventions and other medical needs (e.g., durable medical equipment, wound care)
Your Discharge Planning Checklist:

For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting
NAME: ________________________________
Reason for admission: ________________________________

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (a family member or friend who may be helping you) are important members of the planning team. Below is a checklist of important things you and your caregiver should know to prepare for discharge.

Instructions:

• Use this checklist early and often during your stay.
• Talk to your doctor and the staff (like a discharge planner, social worker, or nurse) about the items on the checklist.
• Check the box next to each item when you and your caregiver complete it.
• Use the notes column to write down important information (like names and phone numbers).
• Skip any items that don’t apply to you.
Action Items

• What’s Ahead?
  – Care after discharge and by whom

• Your Health
  – What to watch for and how to respond
  – Drug list

• Recovery and Support
  – ADLs, Social Worker

• For the Caregiver
<table>
<thead>
<tr>
<th>ACTION ITEMS</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What’s Ahead?</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Ask where you will get care after discharge. Do you have options (like home health care)? Be sure you tell the staff what you prefer.</td>
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<tr>
<td>☐ If a caregiver will be helping you after discharge, write down their name and phone number.</td>
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<tr>
<td><strong>Your Health</strong></td>
<td></td>
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<tr>
<td>☐ Ask the staff about your health condition and what you can do to help yourself get better.</td>
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</tr>
<tr>
<td>☐ Ask about problems to watch for and what to do about them. Write down a name and phone number to call if you have problems.</td>
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## Action Items
– Prompt Hospital Staff

<table>
<thead>
<tr>
<th>ACTION ITEMS</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Use “My Drug List” on page 5 to write down your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.</td>
<td></td>
</tr>
<tr>
<td>☐ Review the list with the staff.</td>
<td></td>
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<tr>
<td>☐ Tell the staff what drugs, vitamins, or supplements you took before you were admitted. Ask if you should still take these after you leave.</td>
<td></td>
</tr>
<tr>
<td>☐ Write down a name and phone number to call if you have questions.</td>
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<tr>
<td>ACTION ITEMS</td>
<td>NOTES</td>
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<td>----------------------------------------------------------------------------</td>
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<tr>
<td>☐ Ask for written discharge instructions (that you can read and understand)</td>
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<tr>
<td>and a summary of your current health status. Bring this information and</td>
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<tr>
<td>your completed “My Drug List” to your follow-up appointments.</td>
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<tr>
<td>☐ Use “My Appointments” on page 5 to write down any appointments and tests</td>
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<tr>
<td>you will need in the next several weeks.</td>
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<tr>
<td>For the Caregiver</td>
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<tr>
<td>☐ Do you have any questions about the items on this checklist or on the</td>
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<tr>
<td>discharge instructions? Write them down and discuss them with the staff.</td>
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<td>☐ Can you give the patient the help he or she needs?</td>
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<tr>
<td>☐ What tasks do you need help with?</td>
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<tr>
<td>☐ Do you need any education or training?</td>
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<tr>
<td>☐ Talk to the staff about getting the help you need before discharge.</td>
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<tr>
<td>☐ Write down a name and phone number to call if you have questions.</td>
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<td>☐ Get prescriptions and any special diet instructions early, so you won’t</td>
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<td>have to make extra trips after discharge.</td>
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</table>
My Drug List

Fill out this list with all prescription drugs, over-the-counter drugs, vitamins, and herbal supplements you take. Review this list with the staff.

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>WHAT IT DOES</th>
<th>DOSE</th>
<th>HOW TO TAKE IT</th>
<th>WHEN TO TAKE IT</th>
<th>NOTES</th>
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My Appointments

<table>
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<tr>
<th>APPOINTMENTS AND TESTS</th>
<th>DATE</th>
<th>PHONE NUMBER</th>
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Taking Care of Myself: A Guide for When I Leave the Hospital

When you leave the hospital, there are a lot of things you need to do to take care of yourself. You need to see your doctor, take your medicines, exercise, eat healthy foods, and know whom to call with questions or problems. This guide helps you keep track of all the things you need to do.

My name: 

When I’m leaving the hospital 

If I have questions or problems, I should call:
INTERPRETIVE DANCE
EXPERIENCING SOME TECHNICAL DIFFICULTIES
Understanding and Execution of Discharge Instructions

Eric A. Coleman, MD, MPH,1 Amita Chugh, EdS,1 Mark V. Williams, MD,2 Jim Grigsby, PhD,1,3 Jeffrey J. Glasheen, MD,1 Marlene McKenzie, RN, MS,1 and Sung-Joon Min, PhD1

- Health literacy, cognition, and self-efficacy predictors of successful understanding and execution of instructions.
- Neither discharge diagnosis nor complexity of discharge instructions was found to be a significant predictor of these outcomes.
- Need reliable protocols that identify patients at risk for poor understanding and execution of hospital discharge instructions.
- And provide customized approaches to meet them at their respective levels.
Discharge Patient Education Tool

Hospital Patient Safe-D(ischarge) Project

Name: ___________________________ Phone Number: ___________________________

Admission Date: _______________ Discharge Date: _______________ Days in the Hospital: ____

Primary Care Doctor: ___________________________ Phone Number: ___________________________
Hospitalist Doctor: ___________________________ Phone Number: ___________________________

Other Doctor: ___________________________ Specialty: ___________________________
Other Doctor: ___________________________ Specialty: ___________________________
Other Doctor: ___________________________ Specialty: ___________________________

BOOSTING THE DISCHARGE PROCESS TO IMPROVE OUTCOMES AND REDUCE UNNECESSARY READMISSIONS
• **DIAGNOSIS**
  – I had to stay in the hospital because: _______
  – The medical word for this condition is: _______
  – I also have these medical conditions: _______

**TESTS**

<table>
<thead>
<tr>
<th>While I was in the hospital I had these tests:</th>
<th>which showed:</th>
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</table>

**TREATMENT**

<table>
<thead>
<tr>
<th>While I was in the hospital I was treated with:</th>
<th>The purpose of this treatment was:</th>
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</table>
FOLLOW-UP APPOINTMENTS
________After leaving the hospital, I will follow up with my doctors.

(initials)
Primary Care Doctor: _____________________________ Phone Number: _____________________________
DATE: ________________, ___ ___, 200__ TIME: ____:____ ___ m

Specialist Doctor: _____________________________ Phone Number: _____________________________
DATE: ________________, ___ ___, 200__ TIME: ____:____ ___ m

FOLLOW-UP TESTS
________After leaving the hospital, I will show up for my tests.

(initials)

<table>
<thead>
<tr>
<th>TESTS</th>
<th>LOCATION</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>__________, ___ _<strong>, 200</strong></td>
<td><strong><strong>:</strong></strong> ___ m</td>
</tr>
</tbody>
</table>

Call your Primary Care Doctor for the following:

Warning signs

1) 4)

LIFE STYLE CHANGES
________After leaving the hospital, I will make these changes in my activity and diet.

(initials)
Activity: _____________________________, because _____________________________
Diet: _____________________________, because _____________________________

BOOSTING THE DISCHARGE PROCESS TO IMPROVE OUTCOMES AND REDUCE UNNECESSARY READMISSIONS
What Should Patients Do?

SORRY TO INTERRUPT YOUR INTERPRETIVE DANCE, BUT IS THERE A PRINTOUT THAT GOES WITH YOUR EXPLANATION?