Preventing Avoidable Readmissions Together: Improving Discharge Summaries

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Today’s Objectives

• Identify elements of a complete discharge summary through examples and use of a scoring tool
• Identify strategies for motivating provider behavior change
• Develop an action plan for improving the quality of discharge instructions in your organization
# PART Program Overview

## Target Conditions (CHF, AMI, Pneumonia, COPD)

<table>
<thead>
<tr>
<th>Phase</th>
<th>Timeframe</th>
<th>Focus</th>
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<tbody>
<tr>
<td>Phase 1</td>
<td>4-9 months</td>
<td>Focus on Implementing Transitional Records and Patient Education</td>
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<td>Phase 2</td>
<td>10-15 months</td>
<td>Focus on Discharge Summary Timeliness and Quality</td>
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<td>Phase 3</td>
<td>16-18 months</td>
<td>Focus on Timely Follow Up Appointments and Post-Discharge Contact</td>
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<tr>
<td>Maintenance</td>
<td>21-24 months</td>
<td>Continued Implementation and Maintenance (Sustainability and Spread)</td>
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### Planning
- (0-3 months)
  - Process Mapping and Root Cause Analysis

### Community Engagement
“Why do we write in the chart at all?”

Top 3 Reasons:

1. Billing
   • Physician payment
   • Hospital payment

2. Medical/Legal

3. **Concise and precise communication among healthcare professionals**
Common Discharge Summary Deficiencies

• Medical Errors:
  – 49% of patients had at least one error at hospital discharge
  – Types of Errors
    • Medication continuity errors (present in 42%)
    • Test follow up errors (8%)
    • Work up errors (12%)

• Adverse Events:
  – 23% with adverse events
  – Adverse events defined as:
    • New or worsening symptoms
    • Unscheduled MD visit or readmission
    • Death

• Hospital Readmissions
  – 19.6% of Hospitalized Medicare Patients discharged within 30 days
  – 34% of hospitalized Medicare Patients readmitted within 90 days
  – $17.4 Billion excess cost

Care Transitions

Only **12-33%** of discharge summaries available at first follow up

Many summaries leave out important information

- 14% omit hospital course
- 17% omit responsible inpatient provider
- **21%** omit discharge medications
- 38% omit key test results
- 65% omit pending tests at discharge
- **91%** omit patient counseling/instructions

Key Discharge Summary Attributes

Timely

Clear, concise, complete

Forward looking
  - Medications reconciled
  - Pending tests enumerated
  - Specific follow up plans noted
Discharge Summary Components (1)

1. **Preliminary Information** (Spell all names)
   - Patient name, Medical record number
   - Dates of Admission/Discharge
   - Attending Physician, Service
   - Person Dictating
   - Referring/Primary Care Provider (Include contact information)
Discharge Summary Components (2)

2. Admission Information
   - Chief Complaint on admission
   - HPI (Brief, including presenting symptoms and admitting impressions/diagnoses)
   - Pertinent PMH/PSH/SHx/FHx
   - Allergies/Reactions
   - Admission Medications (Unless changes noted in discharge med list)
   - Admission Physical Exam (Pertinent findings only)
   - Diagnostic tests (Pertinent test results only, not a complete list; Recite key findings rather than entire reports)
   - Procedures (List major/invasive procedures)
   - Consultations (List services, details to go in the Hosp Course section)
Discharge Summary Components (3)

3. **Hospital Course**
   - Problem based
   - Each problem/diagnosis gets it’s own paragraph
   - Should answer the following questions for each problem
     - What team thought was going on and why?
     - What was done?
     - What happened?
     - What next?
Discharge Summary Components (4)

4. Discharge Information
   - Discharge Diagnoses (Primary and secondary)
   - Discharge Medications (Note medications deleted, changed, or added in relation to the admission medication list)
   - Pending laboratory/radiology/pathology tests and/or Required follow up tests
   - Disposition (To home or another facility noting aftercare services such as PT, OT, or infusion therapy)
   - Condition upon discharge (level of consciousness, orientation, limitations in ambulation or ADLs, where applicable)
   - Patient Instructions
     - Activity
     - Diet
     - Other specific patient instructions (Parameters for calling MD, wound care, etc.)
   - Code status at the time of discharge
   - Follow up appointments (Ideal if specific provider, date, time)
Case 1
What’s Missing?

MEDS?
How to Document Discharge Meds

• Include a complete admissions medication list AND a complete discharge medications list
• Complete an ‘annotated’ discharge medications list. For example,

  • **Discharge Medications:**
  • Medications Continued:
    1. Metoprolol 25 mg PO BID
    2. Lisinopril 20 mg PO daily

  • **New Medications**
    1. Amlodipine 10 mg PO daily

  • **Discontinued Medications**
    1. Hydrochlorothiazide 25 mg PO daily
Case 2
Notice Anything Wrong?

Patient Name: Jones, George
MRN: 123456789
Admitted: 10/07/2011
Discharged: 10/15/2011
Service: Cardiology
Attending: [name omitted]
Chief Complaint: “I couldn’t get air”
Admitting Diagnosis: Congestive heart failure exacerbation

Follow Up Plans:
1. [name omitted], Cardiothoracic Surgery, October 23, 2011
2. [name omitted], Primary Care, November 20, 2011

Date Dictated: 11/23/2011
Date Transcribed: 11/23/2011
Key Discharge Summary Attributes

Timely

Clear, concise, complete

Forward looking

– Medications reconciled
– Pending tests enumerated
– Specific follow up plans noted
Case 3
How Could We Give the PCP an Assist Here?

**Condition at Discharge**

**DISCHARGE DIAGNOSIS:**
1. Autoimmune hepatitis.
2. IgA nephropathy.
3. Possible recurrent cellulitis.
4. Psoriasis.

**DISCHARGE MEDICATIONS:**
1. Imuran 50 mg p.o. daily.
2. Ferrous sulfate 325 mg p.o. daily.
3. Prednisone 5 mg p.o. daily.
4. Ursodiol 1250 mg p.o. daily.
5. Lovaza 2 g p.o. b.i.d.
6. Clobetasol topical cream.
7. Lasix 40 mg p.o. daily.
8. Lisinopril 10 mg p.o. daily.
9. Doxycycline 100 mg p.o. b.i.d.

**PATIENT DISPOSITION:** Patient is discharged to home for self-care.

**DISCHARGE PLAN:** He is to follow up with his primary care physician within 1 week to recheck a BMP and renal function, as well as improvement in the erythema of his left thigh. He should follow up with [blank] in Hepatology Clinic as previously scheduled. He should follow up with Dermatology and Rheumatology per their recommendations. He was advised to continue a low-sodium diet, and to call for fevers greater than 100.5, worsening redness of his left thigh, intractable nausea and vomiting, swelling of his left leg.

**REFERRING PHYSICIAN:** [Blank]
Case 4
What's Missing?

1. Discharge Diagnoses
2. Discharge medication list
3. Discharge condition
4. Tests pending at discharge,
5. Specific follow up plans

HOSPITAL COURSE: [redacted] is a 63-year-old white male with history of coronary artery disease, status post MI 11 years ago with a recent left heart cath on 07/01 with in-stent stenosis of the LAD, AAA, cirrhosis, bladder cancer, and hypertension. He was transferred from [redacted] after 3 syncopal episodes that resulted in L1 spinal fracture after a fall. This L1 fracture was to be repaired by neurosurgery.

1. Cardiovascular: The patient was ruled out for cardiac ischemia with cycle of CIPs and serial EKGs. An echocardiogram from 08/30 showed no regional wall abnormalities and an EF of 66%. As the patient recently underwent a left heart catheter and echocardiogram done here was normal, there was no concern for a new ischemic cardiac event as a culprit for the multiple syncopal events. We do, however, recommend using an event monitor after discharge to monitor for cardiac arrhythmias. Should there be any abnormalities in this test, we would take action as needed.

2. Musculoskeletal System: An L1 fracture was planned to be repaired by neurosurgical team on 08/31. We consulted with Neurosurgery on 08/30, and spinal films from 08/30 showed a stable L1 fracture. Surgical intervention is not necessary at this time. The patient was given a Cybertych back brace, was told to wear it at all times. He should refrain from heavy lifting (over 10 pounds) and other strenuous activity. Should the patient experience new leg or back pain, he should return to the emergency room. The patient should follow up with neurosurgeon, Dr. [redacted], 3-4 weeks, and new spinal films will be repeated before this appointment. Please contact us should you have any further questions or concerns regarding this patient.
Tips on the ‘Discharge Section’

• List the primary and all secondary diagnoses addressed during the hospital stay, including complications
• State the condition of the patient at discharge...
  – “Condition at Discharge: Mr. Jones was alert and oriented, but still had moderate pain in his foot. He was ambulating with a cane.”
• Briefly summarize instructions given to the patient.
  – “Patient Instructions: Mr. Jones is instructed to paint his wound with betadine twice daily and wrap it loosely in clean gauze.”
• Briefly list all test pending at discharge
  – “Tests Pending at Discharge: None.”
### PART Discharge Summary Abstraction Tool

<table>
<thead>
<tr>
<th>Discharge Summary Attribute</th>
<th>Absent</th>
<th>Present</th>
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<tbody>
<tr>
<td>Timeliness (dictated within &lt;72 hours from discharge date)?</td>
<td></td>
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<tr>
<td>Discharge diagnoses present?</td>
<td></td>
<td></td>
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<tr>
<td>Hospital course present?</td>
<td></td>
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<tr>
<td>Discharge medications listed?</td>
<td></td>
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<tr>
<td>Follow up plans described (i.e. clinic appointments)?</td>
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<tr>
<td>Tests pending at time of discharge?</td>
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<tr>
<td>Notes:</td>
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</table>
Grading Discharge Summaries
Questions and Discussion

A+
Improving Discharge Summaries: Getting Started
Process Mapping: A Deeper Dive

1. Patient nearing hospital discharge or recently discharged
2. Provider types or dictates discharge summary
3. Discharge summary is transcribed
4. Discharge summary reviewed and signed by the provider
   - Discharge summary is uploaded into the health record system (available internally)
   - Discharge summary faxed to primary care provider (available externally)
Clinical Champions

• Provider Education
  – Necessary, yet rarely sufficient
• Addition of local opinion leaders associated with improved implementation success in studies of clinical guideline adherence


*WHO ARE YOUR LOCAL CLINICAL CHAMPIONS?*
Audit and Feedback

- Common and effective strategy
- Easy to implement
- PART Discharge Summary abstraction tool can enable:
  - Measurement of baseline performance
  - Ongoing performance tracking
PART Discharge Summary Format

1. Preliminary Information
   - Spell all names
   a. Patient name, medical record number
   b. Dates of admission/discharge
   c. Attending physician, service
   d. Person dictating
   e. Referring/Primary care provider (include contact information)
   f. Discharge diagnoses (primary and secondary)

2. Admission Information
   a. Chief complaint on admission
   b. History of present illness (brief, including presenting symptoms and admitting impressions/diagnoses)
   c. Pertinent PMH, PSH, SHx, and FHx
   d. Allergies/Reactions
   e. Admission physical exam (pertinent findings only)
   f. Diagnostic tests (pertinent test results only, not a complete list; recite key findings rather than entire reports)
   g. Procedures (list major/invasive procedures)
   h. Consultations (list services, details to go in the hospital course section)

3. Hospital Course
   a. (Problem based, formatted in separate concise paragraphs)

4. Discharge Information
   a. Discharge medications (note medications deleted, changed, or added in relation to the admission medication list)
   b. Pending laboratory, radiology, pathology tests and/or required follow up tests
   c. Disposition (to home or another facility, noting aftercare services such as physical therapy, occupational therapy, or infusion therapy)
   d. Condition upon discharge (level of consciousness, orientation, and limitations in ambulation or activities of daily living, where applicable)
   e. Patient Instructions
      1. Activity
      2. Diet
      3. Other specific patient instructions (parameters for calling doctor, wound care, etc.)
   f. End-of-life care preferences/code status at the time of discharge
   g. Follow up appointments (ideal if specific provider, date, time)
Incentives

Vs.
Questions and Discussion