How to Improve the Discharge Process

Michelle Mourad, MD
Ryan Greysen, MD
Who are we? Why are we here?
I mean BOB is the reason we are all really here. Do you have a BOB where you are?

Or perhaps you like us are passionate about improving the discharge process.
Discharging patients: It’s complicated...
And lots of things can go wrong…

- No appointment
- No PMD communication
- No D/c summary
- Insurance check?
- Med rec?
- Pending tests?
- RN transcribing error
- Poor health literacy
- No point of contact after discharge
Workshop goals and overview

- **Part 1:** tackling discharge issues (in a broken system)
- **Part 2:** Best practices around discharge
- **Part 3:** Making quality discharge a reality
Uh Michelle, this sounds pretty complicated. Are you sure we can improve this?

You’re right. I’m smiling, but I’m scared inside. Let’s start with something simpler. This is pretty complex. Are you sure we can improve this?
How to Draw a Pig?

Michelle Mourad, MD
Ryan Greysen, MD
Drawing a Pig

1) Draw the side profile of a pig, centered on the page.

2) Make sure the pig's head is facing left.

3) The pig should be drawn large enough so that a piece of it is in every box EXCEPT the top right.

4) You have 2 minutes to draw your pig.

5) Look up when you are done.
Compare pigs!
### Let's try that again

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Sub-Task</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Draw a letter M at the top left intersection.</td>
<td>1.1</td>
<td>Bottom center of M touches intersection</td>
</tr>
<tr>
<td>2</td>
<td>Draw letter W at bottom left intersection</td>
<td>2.1</td>
<td>Top center of W touches intersection</td>
</tr>
<tr>
<td>3</td>
<td>Draw letter W at bottom right intersection</td>
<td>3.1</td>
<td>Top center of W touches intersection</td>
</tr>
<tr>
<td>4</td>
<td>Draw arc from letter M to top right intersection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Draw another arc from top right intersection to bottom right W</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Draw an arc between the two bottom Ws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Draw the letter O in center left box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Draw arc from letter M to tangent of the circle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Draw arc from left W to tangent of the circle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Draw an arc for the mouth</td>
<td>10.1</td>
<td>Half way between the W and circle</td>
</tr>
<tr>
<td>11</td>
<td>Draw an arc for the eyes</td>
<td>10.2</td>
<td>Must be a happy pig</td>
</tr>
<tr>
<td>12</td>
<td>Draw cursive letter e near top of arc on right</td>
<td>11.1</td>
<td>Half way between the M and circle</td>
</tr>
<tr>
<td>13</td>
<td>Draw two dots in middle of circle for pigs’ nose.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Look up when you are finished...
Compare Pigs!
Third time is the charm!

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Sub-Task</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Draw a letter M at the top left intersection.</td>
<td>1.1</td>
<td>Bottom center of M touches intersection</td>
</tr>
<tr>
<td>2</td>
<td>Draw letter W at bottom left intersection</td>
<td>2.1</td>
<td>Top center of W touches intersection</td>
</tr>
<tr>
<td>3</td>
<td>Draw letter W at bottom right intersection</td>
<td>3.1</td>
<td>Top center of W touches intersection</td>
</tr>
<tr>
<td>4</td>
<td>Draw arc from letter M to top right intersection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Draw another arc from top right intersection to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>bottom right W</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Draw an arc between the two bottom Ws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Draw the letter O in center left box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Draw arc from letter M to tangent of the circle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Draw arc from left W to tangent of the circle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Draw an arc for the mouth</td>
<td>10.1</td>
<td>Half way between the W and circle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10.2</td>
<td>Must be a happy pig</td>
</tr>
<tr>
<td>11</td>
<td>Draw an arc for the eyes.</td>
<td>11.1</td>
<td>Half way between the M and circle</td>
</tr>
<tr>
<td>12</td>
<td>Draw cursive letter e near top of arc on right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Draw two dots in middle of circle for pigs’</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>nose.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Look up when you are finished...
Lessons from Pig #1: Left on your own, every pig (or discharge) is different. Sure, it’s quick to draw your own pig, but guiding improvements is a challenge.
**Lessons from Pig #2:** It’s hard to follow instructions when you don’t know what your goal or end product is. It takes too much time and makes standardization hard.
Lessons from Pig #3: Knowing the end product helps in following directions and everyone produces consistent quality pigs!
- Drawing a Pig = Discharging a Patient

- You can’t expect everyone to automatically follow all best practices without cues

- Provide instructions, examples and make the process easier
FIX IT!!
Don’t we need one of these?
Workshop goals and overview

- **Part 1:** What do we know about readmissions?

- **Part 2:** Best practices around Discharge

- **Part 3:** Making Best Practices a Reality
Your first task:

What should be standard for every discharge?

- With your table make a 5-item checklist to standardize every discharge
- You have 20 minutes
What’s on your list?

1. Evidence
2. Best practice
3. What we’re doing at UCSF
4. What are you doing?
Medication Reconciliation
Medication Reconciliation: Evidence

- 15-30% of patients have med discrepancies during hospitalization
- Age, high-risk meds, and polypharmacy are risk factors
- Patients with med discrepancies twice as likely to be readmitted


Medication Reconciliation: Best Practices

- Confirm admission med list with PCP or pill bottles if possible
- Discharge pharmacy consult for high-risk meds or polypharmacy
- Careful documentation of med reconciliation including “stop” meds in patient instructions and discharge summary
- Ensure access to meds at discharge
The following is a complete list of the patient's medications upon discharge.

(Please include why the medication was stopped, and if it was replaced by a new medication)

**Medications Stopped during this Hospitalization:**
- ASA 81mg daily
- Naproxen 500mg BID

(For antibiotics - please include start and end date of medication)

**New Medications Started on this Hospitalization and Medications to be Taken at New Doses:**
- Doxycycline 200mg po BID x 5 days (12/4/2010 - 12/8/2010)

(Please include dose and frequency)

**Previous Medications To Be Taken Regularly After Discharge:**
- Metoprolol 50mg po bid
- Losartan 50mg po daily
- Lipitor 40mg po at bedtime
- Levothyroxine 75mcg po daily
- Flomax 0.4mg po daily

The medications listed above should serve as a guide for referring physicians only. For official patient medication reconciliation and the most accurate source of patient medications, please see the pharmacy generated Discharge Medication note in UCare or the patient's discharge prescription.
Medication Teaching – Evidence

- Multiple Articles cite improvements in...

Reduction of 30-Day Postdischarge Hospital Readmission or Emergency Department (ED) Visit Rates in High-Risk Elderly Medical Patients Through Delivery of a Targeted Care Bundle

 Bruce E. Koehler, MPH
 Kathleen M. Richter, MS, MPH, CDS
 Liz Youngblood, RN, MPH

1 Institute for Health Care Research and Improvement, Baylor Health Care System, Dallas, Texas.
2 Department of Patient Services, Baylor Health Care System, Dallas, Texas.

when trained pharmacists do discharge teaching.

- Unfortunately Pharmacists are a limited resource at many institutions
Medication Teaching – The Evidence

- High Risk meds are...

*High risk!*

---

Less Is More

Potentially Inappropriate Medications Defined by STOPP Criteria and the Risk of Adverse Drug Events in Older Hospitalized Patients

Hilary Hamilton, MB, MRCPI; Paul Gallagher, PhD, MRCPI; Cristin Ryan, PhD, MPSI; Stephen Byrne, PhD, MPSI; Denis O'Mahoney, MD, FRCPI
High Risk Meds List

**Pharmacy Consult**

- Anticoagulant medications (enoxaparin, coumadin, etc.)
- Any injected medication (insulin, enoxaparin, neutropen, epoetin, etc.)
- Changes to long-acting opiate regimens (fentanyl patch, MS Contin, Kadian, etc.)
- Antibiotics needing prior authorization (i.e. linezolid, cefpodoxime, PO vanco, etc.)
- Patients admitted with a drug related complication
- Any other questions, concerns, or special needs you may have for patients at discharge
High Risk Medications that Require Pharmacy Consultation

**Anticoagulation:**
- Warfarin (Coumadin)
- Enoxaparin (Lovenox)
- Fondaparinux (Arixtra)
- Dalteparin (Fragmin)
- Dabigatran (Pradaxa)

**Injectables:**
- Insulins
- Erythropoetin (Epoetin)
- Darbepoetin (Aranesp)
- Filgrastim (Neupogen)
- Pegfilgrastim (Neulasta)
- Methylniltrexone (Relistor)

**Oral Antibiotics (likely to need Prior Authorization)**
- Linezolid (Zyvox)
- Valganciclovir (Valcyte)
- Voriconazole (Vfend)
- Rifaximin (Xifaxan)
- Vancomycin (Vancocin)
- Cefpodoxime
- Itraconazole solution (Sporanox)

**Long Acting Opioids (new start insurance coverage and pharmacy availability)**
- Fentanyl Lollipops (Actiq)
- Fentanyl Patches (Duragesic)
- Morphine Sustained Release (MS Contin, Kadian)
- Oxycodone Sustained Release (Oxycontin)
- Morphine Liquid 20mg/ml (Roxanol)
- Oxycodone Liquid 20mg/ml (Roxicet)

**Others**
- Naloxone Oral Solution
- Tadalafil (Adcirca)
- Sildenafil (Revatio)
- Bosentan (Tracleer)
## Medication Education

**DISCHARGE PRESCRIPTION & MEDICATION LIST**

PLEASE BRING THIS LIST TO YOUR PHARMACY AND ALL CLINIC VISITS.

PROVIDERS: MAKE SURE TO RECONCILE ALL PRE-HOSPITALIZATION AND CURRENT MEDICATIONS. LIST ALL MEDICATIONS THAT WILL BE TAKEN AFTER DISCHARGE, INCLUDING HERBALS AND OTC’S.

**PATIENT’S ALLERGIES**

### THE PATIENT WILL BE TAKING THESE MEDICATIONS:

**EL PACIENTE ESTÁRÁ TOMANDO ESTOS MEDICAMENTOS**

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>STRENGTH</th>
<th>QTY</th>
<th>DIRECTIONS</th>
<th># OF REFILLS</th>
<th>DO NOT FILL</th>
<th>TIME TO LAST DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amiodarone</td>
<td>300mg</td>
<td>45</td>
<td>PO bid x 2 wks then PO daily</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nexium</td>
<td>40mg</td>
<td>20</td>
<td>PO daily</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pepcid</td>
<td>40mg</td>
<td>30</td>
<td>PO daily</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levoxyn</td>
<td>12.5mg</td>
<td>30</td>
<td>PO daily</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coumadin</td>
<td>4mg</td>
<td>20</td>
<td>PO q12hs</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mel1</td>
<td>30g</td>
<td>30</td>
<td>PO daily</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evista</td>
<td>30g</td>
<td>30</td>
<td>PO daily</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vit B12</td>
<td>—</td>
<td>—</td>
<td>Sub q1w</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benadryl</td>
<td>—</td>
<td>10</td>
<td>PO Prn</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### THE PATIENT WILL NOT BE TAKING THESE MEDICATIONS ANYMORE:

**EL PACIENTE YA NO ESTÁRÁ TOMANDO ESTOS MEDICAMENTOS NUNCA MAS**

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>STEPS</th>
<th>DIRECTIONS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candesartan</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT’S ADDRESS**

**PATIENT’S PHARMACY**
# UCSF Medication List

Follow this schedule of medications EACH DAY. Bring this form to all of your medical appointments.

**Allergies:**

**IMPORTANT! STOP these medications**

1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________
6. __________________________

<table>
<thead>
<tr>
<th>Medication</th>
<th>Why am I taking this medicine?</th>
<th>Dose</th>
<th>AM</th>
<th>Noon</th>
<th>PM</th>
<th>Bed-Time</th>
<th>Other Instructions ex. As needed for pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Got discharge meds?

Worried that your 14M patient might not make it to the pharmacy to pick up their new antibiotics or steroids?

Use the Walgreens across the street to call or fax in meds. A delivery service is also available on request.

For med ordering follow these easy steps:

1. Check the Pharmacy Preference form to verify your patient is interested in Walgreens services
2. Fill out the prescription the day before discharge.

Using the Med Fax Order Form:

3. Fill out the MD part of the order form:
4. Write an order for the clerk to fax the discharge prescription to Walgreens and call Walgreens 10 minutes later to confirm the receipt of the fax.
PCP Communication
PCP Communication – Evidence

- 75% of discharge summaries NOT available at time of first follow-up appointment with PCP
  - 24% caused limitations to PCP clinical plan
  - One study found a trend to increased readmissions if a discharge summary was missing

- PCPs unaware of 62% of the pending test results after discharge
  - 37% were considered actionable

Kripilani et al, Journal of Hospital Medicine, 2007
PCP Communication – Best Practice

- Make PCP info easy for inpatient providers to find
- Talk to your admissions department about automating communication on admission
- Involve PCPs early
- Consider setting the bar for the discharge summary within 24 hrs
- Communicate the discharge diagnosis, medications, results of procedures, pending test results, follow-up arrangements, and suggested next steps.
- Within 1 week, a detailed discharge summary should have been received.
Dictated discharge summaries

ADMITTED: 01/28/2008  DISCHARGED: 12/11/2008

REFERRING PHYSICIAN: Susan Chang, MD, Box 0372, 400 Parnassus Ave., UC Clinic 808, UCSF, San Francisco, CA 94143-0372.

HOSPITAL COURSE BY PRBLEM:
1. Glioblastoma multiforme: The patient in the setting of Avastin and physical therapy made remarkable recovery such that 2-3 weeks prior to discharge he was able to articulate, although minimally, follow commands and move all 4 extremities. He still required significant assist from physical therapy and occupational therapy; however, exceeded physicians’ expectations for his improvement given the progression of his disease on neuroimaging. He was re-imaged for the last time with an FLAIR brain without and with gadolinium on December 8th that showed marked interval decrease in flare hypointensity mass effect enhancement consistent with positive treatment effect. There was also reduced diffusion on the anterior and superior aspect of the resection cavity as well as within the left temporal lobe in the region which previously demonstrated extensive enhancement that may represent treatment-related cytotoxic edema. Overall, the patient had tolerated the Avastin extremely well and had made remarkable progress in terms of rehabilitation and was recommended for some time for SNF physical therapy, which his was able to handle adequately and maintain minimal decline. Please see below for further discussion. The patient was finally re-advised with Avastin on December 19th, which he tolerated well and will be due for another treatment in approximately 2 weeks which can be done as an outpatient. At the time of discharge the patient was, in terms of bed mobility and transfers, was able to perform a partial leg roll to the left with the use of the bed rail. He was verbalizing and was able to transfer independently. He also had much improved initiation of transfer along with improved motor planning and output. In terms of sitting, balance and endurance, he was able to sit at the edge of the bed for 10 minutes. He required some additional assist for static sitting. He was also able to scoot 6 inches to the left while sitting at edge of bed.
2. Diabetes: The patient, as he had transferred, was able to sit to stand with a steady lift and the patient initiated transfer appropriately with use of upper extremities. He was also able to stand near upright during the first trial with max assist. The physical therapist did recommend further intensive physical therapy. Further follow up imaging and treatment will be per his outpatient provider, Dr. Chang.
3. Volume overload and hypernatremia: Both of these issues were addressed after the last day of Avastin on the 1st week of his hospital course due to the lack of impact on clinical management, his hypernatremia had long since resolved.
4. Candida ventriculitis: He has been discharged from the hospital. He was maintained on Lantus 25 units in the morning and 15 units in the evening as well as 15 units prior to meals with additional insulin based on meal scale coverage. He tolerated this regimen extremely well with no episodes of hypoglycemia and minimal hyperglycemia in the inpatient setting and should be continued as an outpatient.
5. Clostridium difficile: As noted in prior dictation he had suffered from Clostridium difficile colitis; however, he was negative for C. diff twice, most recently on December 6th. He was noted to have loose bowel movements while preparing for discharge. The clinical suspicion was low for Clostridium difficile infection as he had just been negative several days prior and only then having 1 loose bowel movement without any abdominal pain. Given his prior complications with Clostridium difficile infections previously, a C. diff toxin assay was sent and this will be followed up and the patient’s wife will be notified if it is in fact positive. The patient’s wife specifically stated that she understood and agreed and would await the phone call should the test become positive. She agreed and understood that treatment could be done as an outpatient if begun quickly and administered appropriately with either Flagyl or oral vancomycin should the need arise.
6. Ecthyma gangrenosum continued to slowly improve. Urology had previously consulted as mentioned previously in other dictations, that surgery was not indicated secondary to the wound healing and poor candidacy for surgery. Accuzyne to the thigh wound was continued as well as hydrogel and Vaseline gauze dressings to the perineal wound, which was healing quite well by secondary intention.
7. Nephrolithiasis: He did have a UA checked multiple times in the month of December for intermittent possible hematuria and cloudy urine. UAs sent on December 1st, 2nd, 4th, 7th and 9th never revealed any evidence of infection. It did, however, show evidence of calcium oxalate crystals in the setting of large hemoglobin and more than 50 red blood cells per high powered field. The patient was treated with Toradol for pain control and hydration and complained of very minimal if any pain during this time. The last UA December 9th still showed persistent calcium oxalate stones; however, the patient was clinically asymptomatic and doing well.
8. Abdominal pain: Intermittently the wife would report that the patient did not mind suffering from abdominal pain though it was reproducible on the clinical exam. However, there was an abdominal CT of the abdomen and pelvis done on December 8th to better characterize the patient’s anatomy. It was a non-contrast exam to minimize harm to the patient for his benefit, given that he was clinically asymptomatic during his exam. His primary concern was the risk of contrast outweighing the benefit of imaging, given the clinical acuity in the setting of a within-normal-limit white blood cell count and lack of evidence on clinical examination, that contrast was warranted. However, the wife wished the gallbladder stones, the gallbladder stones, the gallbladder stones, and the gallbladder stones were unremarkable. There is no lymphadenopathy or free fluid present within the abdomen or pelvis. There are no suspicious bony lesions. The heart was normal size. There is a pleural effusion at both lung bases. There was a cyst within segment 6 of the liver. Non obstructive calculi were in the inferior pole of the right kidney.

As suggested from the UA as described above, the inferior vena cava filter was below the level of renal veins in a pericatheter tract along the renal vein. The mid line catheter was confirmed to hang and ending in the inferior vena cava without evidence of loculated fluid was also noted. Of note though, there was concern to maintain pressure. A right external jugular catheter balloon was within the pericatheter tract which the bladder contained free air and was decompressed. As a result of this the Foley catheter was removed and the patient was discharged home.
e-discharge summaries

ADMITTED: 07/13/2010    DISCHARGED: 07/14/2010

Medicine Service:
Bill Area: IMW
Note Type: DISCHARGE SUMMARY
Service: Medicine Service

DISCHARGE SUMMARY

HOSPITAL COURSE:
Admitting Diagnoses / Reasons for Admission
Lower GI Bleed with BRBPR
Acute Renal Failure

Brief Summary of HPI w/ Chief Compliant:
67 yo M with history of CHF presented with a chief complaint of 24 hrs of BRBPR, found to have a Hct of 24 and was admitted for transfusion, supportive therapy and colonoscopy.

Brief Hospital Course By Problem:
1. Anemia/Blood Loss: Secondary to presumed diverticular bleed given rapidity of bleeding sudden onset, and sudden cessation of bleeding in the setting of known diverticulitis. Stabilized overnight, no indication for colonoscopy in am. Followed serial Hct for 48 hours with no recurrent bleeding
   - Hct stable x 48 hrs at 29
   - Normal color and caliber of stool, no melena
   - Will be referred for surgical evaluation next week with colorectal surgeons given 2 previous episodes of severe bleeding requiring hospitalization

2. Acute Renal Failure: Presented severely dehydrated with a creatinine of 2.4 (baseline 1.4) with elevated BUN. Patient received 2L NS bolus, followed by 2 units of crossmatched packed red blood cells.
   - Creatinine resolved to baseline over 24 hrs with steady increase in urine output.

3. CHF: Predominantly diastolic dysfunction at last echo, moderate with some impaired LV relaxation. No htn, volume overload, hx of angina that might suggest need for further work up prior to surgery.
   - Excellent functional status.
   - Continue metoprolol 50mg bid as an outpatient through surgery

Vital Signs on Discharge:
124/86 68 18 98% RA 36.2

Final Physical Exam:
GEN: Pleasant, alert, ready for discharge
CV: RRR nr S1S2 no m/rig JVP at 7, PMI non-displaced
CHEST: CTAB symmetric expansion
ABD: Soft, mild tenderness in RLQ, no distension, no rebound.

New Medications Started on this Hospitalization and Medications to be Taken at New Doses:
- Colace 250mg daily
- Senna 2 tabs daily as needed for constipation

Previous Medications To Be Taken Regularly After Discharge:
- Metoprolol 50mg BID
- Levothyroxin 75mcg daily
- Flomax 0.4mg daily
- Ambien 5mg at bedtime as needed for sleep

The medications listed above should serve as a guide for referring physicians only. For official patient medication reconciliation and the most accurate source of patient medications, please see the pharmacy generated Discharge Medication note in UCare or the patient’s discharge prescription.

FOLLOW-UP PLANS:
Pending Tests & Follow Up Needs for the Primary Care Physician:
1) Anticipate surgical work up for sigmoid colectomy given recurrent bleeding. Will need pre-op eval or post-op home care
2) Patient had a TSH drawn at this admission that was low, he should be followed up with a T4 & T3 after his acute illness has resolved
3) The patient had a CXR on admission demonstrating a 1cm chest nodule

I have reviewed the Pending Labs, Microbiology & Pathology in UCare and this patient has no additional Pending Tests

Discharge Appointments
Please call the following providers for an appointment.
Dr. Mourad: General Medicine Clinic, follow up appointment within two weeks of hospital discharge. Call 353-100 if you do not hear about your appointment by 1/29/10

You have appointments with the following providers:
Dr. J. Supercal @ MTZ 3rd floor at 10:30, call 353-1000 with questions prior to your appt

CONDITION AT DISCHARGE:
Condition on discharge: Fair

Functional Assessment at Discharge/Activity Goals:
Patient requires moderate assist with transfers, progress to independence

Code Status: Full Code

DISCHARGE DIAGNOSIS:
Discharge Diagnoses
- Diverticulosis
- Acute Renal failure - Resolved
- Hypothyroidism

A copy of this document was given to the patient for his/her records and as a means of communicating with his/her primary care physician.
Changing the culture

- Timely Discharge Summary

- Average Time to Intern Signature
- Completed by intern on the day of discharge
FOLLOW UP PLANS

Wave goodbye!
Follow Up Appointments – Evidence

- Evidence for two week follow up appointments

**Relationship Between Early Physician Follow-up and 30-Day Readmission Among Medicare Beneficiaries Hospitalized for Heart Failure**

Adrian F. Hernandez, MD, MHS
Melissa A. Greiner, MS
Gregg C. Fonarow, MD
Bradley G. Hammill, MS

Context: Readmission after hospitalization for heart failure is common. Early outpatient follow-up after hospitalization has been proposed as a means of reducing readmission rates. However, there are limited data describing patterns of follow-up after heart failure hospitalization and its association with readmission rates.

Objective: To examine associations between outpatient follow-up within 7 days of...
Follow Up Appointments – Best Practice

- Follow up within 2 weeks from hospital discharge for General Medicine
- Follow up within 7 days for patients with CHF
- Follow up within 30 days for SNF patients
- Audit and feedback of appointment rates can change behavior: see if your EMR can track this!
- Consider follow-up phone calls by discharge coordinator (RN/NP role)
Follow up appointments

- Can we make a slide about our PCP follow up rates (as referenced in last slide – can improve with audits/feedback!)
Follow Up with patients

Creating a post-discharge hotline to the nurses station or an admin, can be a good first step to understand post discharge issues.
Follow Up Phone Calls

- Some evidence these decrease readmissions
- Some evidence for increased patient satisfaction
- A good opportunity to check what patients understood from discharge instructions
Data from Follow Up Calls

- Able to fill all prescriptions: 76%
- No new meds: 11%
- Unable to fill some or all prescriptions: 13%

- No Insurance Financial Burden: 13%
- Drug Store issue (no stock, wrong meds): 13%
- Patient awaiting Insurance approval: 12%
- Patient had not attempted to fill prescription: 42%
- Pharmacy closed at time of discharge: 6%
- Patient had financial burden: 13%
PATIENT EDUCATION
Patient Education – Evidence

- Nurses spend an average of 8 minutes on discharge
- Less than half of patients understand their discharge diagnosis, medications, etc.

**Original Article**

**Patients’ Understanding of Their Treatment Plans and Diagnosis at Discharge**

**Conclusions:** Less than half of our study patients were able to list their diagnoses, the name(s) of their medication(s), their purpose, or the major side effect(s). Lacking awareness of these factors affects a patient’s ability to comply fully with discharge treatment plans. Whether lack of communication between physician and patient is actually the cause of patient unawareness of discharge instructions or if this even affects patient outcome requires further study.

Patient Education – Best Practice

- Reason for Admission
- Findings from Hospital Stay
- Discharge Diagnoses
- Instructions for Self-Care/Symptom Management at home
- Follow up Plans
- Pending test

- Use Teachback!
Teachback

- Explain discharge instructions to patient
- Assess Recall & Comprehension: Ask Patient to Demonstrate
- Clarify & Tailor the Instructions
- Reassess Recall & Comprehension: Ask patient to Demonstrate
- Assess Recall & Comprehension: Ask Patient to Demonstrate
- Explain discharge instructions to patient
### UCSF Medical Center

#### DISCHARGE/FOLLOW-UP SUMMARY

**PLEASE BRING THIS WITH YOU TO YOUR FIRST DOCTOR VISIT**

<table>
<thead>
<tr>
<th>Diagnosis/Surgeries/Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor at the time of discharge:</td>
</tr>
<tr>
<td>Discharge to: Home □</td>
</tr>
<tr>
<td>Person accepting responsibility for patient: self □</td>
</tr>
<tr>
<td>Mode of transportation: self □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. □</td>
</tr>
</tbody>
</table>

| Home Care Agency: |
| Dr. □ |

| Infusion Company: |
| Dr. □ |

| Equipment Company: |
| Dr. □ |

| Supply Company: |
| Dr. □ |

**Discharge Instructions: Please follow these instructions until your next assignment:**

- If you smoke, STOP ALL smoking/tobacco use.
- Avoid alcohol and blood thinners.

**Name(s) of teaching record(s) for self care instructions:**

**Meds:**
- None □
- See medication schedule (complex meds) as per doctor's orders □
- Reviewed by my pharmacist □
- Reviewed by my nurse □

**Discharge Instructions for Patients Who Do Not Receive a Teaching Record:**

- Name(s) of pamphlet(s) given to patient: None □
- Diet: no restrictions □
- Special diet (specify): none □
- Activity: no restrictions □
- No lifting > 10 pounds for days □
- No driving for days □
- No sexual activity for days □
- Treatments prescribed by your doctor: none □
- Incision care □
- Place dry dressing on after bathing □
- Place wet to damp dressing on(e) □
- Use nebulizer/ inhaler □
- Laugh □
- With return demonstration □

**Notify your doctor if you have any of the following, especially:**

- Fever □
- Blood sugar < 70 or > 400 □
- Shortness of breathing/wheezing □
- Diabetic □
- Blood pressure □
- Headache □

**Signatures:**
- I understand the above instructions and have a copy of them. □
- Interpreter used □

**Discharge RN: □**
- Patient/family: □
- Other identifier #: □
- Discharge date/time: □
New Form

<table>
<thead>
<tr>
<th>PLEASE BRING THIS WITH YOU TO YOUR FIRST DOCTOR VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
</tr>
<tr>
<td>Discharge Date:</td>
</tr>
<tr>
<td>Hospital Doctor:</td>
</tr>
<tr>
<td>Dr</td>
</tr>
</tbody>
</table>

**Referrals / Follow-Up Appointments**

<table>
<thead>
<tr>
<th>Name or Clinic of Test</th>
<th>Provider Name</th>
<th>Location</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

**Home Supplies**

The following Home Health Services were ordered:

- Skilled Nursing
- Physical/Occupational Therapy
- Speech Therapy
- 3-in-1 Commodity
- Oxygen
- Other
- 3-in-1 Commodity
- Oxygen
- Other
- Walker/Rollator
- Hospital Bed
- Wheelchair/Massage
- Heat Pack
- Cold Pack
- N/A
- Medications/Others

**Medications**

My medications were reviewed by:

- My nurse
- My Pharmacist

A copy of my medication schedule was provided to me which I will bring to my clinic appointment.

After leaving the hospital, I will take all of my medications as prescribed.

**Provider Contact Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Smoking Cessation**

If you smoke, STOP ALL smoking/tobacco use.

- Smoker: Plan for quitting

**Emergency Care**

I was in the hospital because:

The medical word for this condition is:

I also have these medical conditions:

- (Including personal risk factors for heart attack and stroke: DM, HTN, high cholesterol, obesity, previous MI or stroke)

**Self Care**

- Diet because:
- Activity because:

**Wound/Urinary Care**

- Self Continue to watch the following things at home:
- My blood pressure
- My blood sugar
- My wound/urinary care

I was given the following instruction materials for self-care:

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
</table>

I agree with the care plan outlined above:

Patient/Surrogate Signature: Date: Time:

Nurse Signature: Date: Time:

An interpreter was used in the communication of discharge instructions.
What do patients go home with?
Your Discharge Information

Please bring this folder to your doctor's appointment

Name
Room Number
Discharge Date
COMMUNICATION WITH NURSES

Does this exist?
Communication with Nurses — Evidence

- No studies on effects of MD-RN communication on quality of discharge or readmission BUT
- RNs more likely than MDs to cite poor communication as reason for delays in discharge
- 30% of observed hospitalists did not communicate with nurse verbally at all during admission
  - MD-RN agreement on plans for medication changes was 59% overall

Rothberg et al. The Relationship Between Time Spent Communicating and Communication Outcomes on a Hospital Medicine Service. JGIM. 2011
Communication with Nurses – Best Practice

- Discharge Time Out
  - Discharge diagnosis
  - Follow-up plans
  - Need for education/training prior to discharge
  - Necessary paperwork completed
  - Anticipated time of discharge.