

FREQUENTLY ASKED QUESTIONS RELATED TO NEW DISCHARGE STANDARDS

- 1. Your standard for Discharge Summary completion used to be 30 days. Does the physician have to be completed within 7 days?**

Standard # 15.06.16 is referring to the actual Discharge Summary *document*. You are correct that the Medical Record, in its entirety, must be completed within 30 days. (This standard is located in 10.01.17) The Discharge Summary document, within that medical record, must be completed and available to the next provider no later than 7 days post discharge.

- 2. Could you please clarify what is meant by “condition at the time of discharge”, found in 15.06.17, #2? Does this mean that a physician must determine the condition such as ‘stable’ or ‘unstable’? Or is it referring to a nursing discharge assessment such as skin intact, alert, oriented, and a description of ADL status?**

“Condition at time of Discharge” refers to the clinical status of the patient upon discharge, as determined by the discharging physician. The example of ‘stable’ would be acceptable. A condition of ‘Unstable’ at the time of discharge would, however, lead one to rethink the appropriateness of the discharge.

- 3. Does the discharge form need to be faxed to the patient’s family doctor or the surgeon who performed their procedure? Our facility only performs surgical procedures and all of our patients will follow-up with the same doctor that performed their surgery.**

Best practice would dictate that the primary care physician would receive the discharge summary (or discharge instructions, should the summary not be available). The reasoning behind this is to assure there is communication of the patient’s current clinical status. It’s possible that the surgery went well, with no infections, etc. But, there is potential for other factors/conditions to be exacerbated due to the invasive nature of the procedure. For example, a patient receives a hip replacement. Surgery went well, there are no signs of infection and the patient seems to be progressing through therapy at an acceptable pace. The patient, however, is diabetic and has been experiencing symptoms of uncontrolled hyperglycemia and sees their primary care provider. It is beneficial to the PCP, and ultimately to the patient, that the PCP have documentation from the hospital stay relating to the recent surgery.

- 4. What has to be in the risk assessment for readmissions?**

Each facility will need to assess their individual populations to determine what risk factors should be screened on their risk assessment for readmission. There is research available which describes issues such as the ability to communicate as a risk factor. You may also want to include things such as available transportation, age, etc. HFAP does not prescribe what should be included, but you want to make sure that it is going to be relevant to preventing readmissions in groups who are currently falling into the ‘readmission’ category.

- 5. Does the facility have to call all discharged patients back within 3 days?**

The answer here is NO. Only patients who are being discharged to home and who have been identified as “At Risk” by your facility’s Risk Assessment would need to have follow-up calls.

- 6. If we transferred a patient to a Skilled Nursing Facility, do we have to call those patients?**

Technically, a ‘transfer to a SNF’ is a discharge from the acute care hospital. These patients may fall out on your Risk Assessment, however, they will be receiving 24 hour care by the next provider. For instance, they are being followed up on by the accepting physician and medications are being administered without action being required on the part of the patient. Making a follow-up phone call to these patients would not be feasible.

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7. How responsible is the hospital for other facilities following our discharge plan for post-discharge care?

HFAP does not expect that a hospital would be responsible for what is ordered / not ordered for a patient by any other provider after the patient has left the hospital. The big concern here is to assist those patients who are not able or who may not be compliant with their own medical regimen.

8. Do these standards apply strictly to inpatients?

YES. At this time, these standards are only applicable to inpatient discharges.

9. In the physician's Discharge Summary, is it acceptable to allow him/her to reference the completed Medication Reconciliation & Discharge Medication List that is also part of the medical record?

This would be absolutely acceptable. HFAP understands that the more times a single event/item is documented in the record, the greater chance there is of an error, which could seriously impact the subsequent care of the patient. Medication Reconciliation is still a required part of the discharge process. The provider is encouraged to refer to this document within their discharge summary in lieu of rewriting all medications and inadvertently making a transcription error or an error of omission. Duplication is not our goal!

10. If our State has a Health Information Exchange, in which all PCPs are members, and we set up the discharge instructions and the discharge summaries to automatically alert the PCP that the documents are available, would this be considered compliant?

YES, this would be compliant. All audit trails in electronic records are considered to be part of the legal medical record. If these alerts are provided to the PCP and the PCP has access to receive those alerts and access to those documents, your facility would be in compliance. Upon survey, you may be asked to produce proof of the automatic alert.

11. Is the intent of the standard to have the follow-up appointments made on behalf of the patient prior to the patient being discharged? If so, then how should we handle those patients being discharged later in the afternoon / evening?

YES, the intent is to have the follow-up appointments made for the patient, prior to the patient's discharge. Facilities should have a process in place that facilitates this on the next available day .

12. Standard 15.06.18 -- my understanding is that this standard regarding the discharge summary can be "any" discharge document completed by the physician that meets the definition...not necessarily the dictated discharge summary. Is that correct? Also, if the discharging physician is the PCP, does that change the intent of the standard? For example, since the PCP and the discharging physician is the same person then they are communicating to "themselves" if there are not other providers involved, correct?

Ideally, the Discharge Summary would be the document which is sent to the PCP, but it is understood that a 'complete' / final summary may not be available at the time of discharge, in which case, the discharge instructions and medication reconciliation document(s) would suffice. As far as the discharging physician being the PCP: depending upon patient load, it would still be prudent to have those documents for the follow up visit. Relying on memory, even after a couple of days is not the most desirable method of managing care.

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13. Discharge instructions---should every document given to the patient be kept in the medical record or can we document that we gave the information to the patient but not actually have copies of what was given?

The best verification method to show that the patient was provided with information is a signed document, but again HFAP is not prescriptive as to the process of a facility. Many facilities have their discharge instructions in duplicate so one can be placed on the chart. This is not mandatory but there does need to be documentation that it was provided.

14. How does standard 15.07.15 #3 correlate with the above standards?

When applicable, #3 of standard 15.07.15 – Glycemic Control, would need to be included in the discharge information. For patients without glycemic control issues/problems, this information is not needed.

15. The physician/nurse discharge instructions and medication list at our facility are copied X3. The patient receives a copy along with verbal instruction, a copy is placed on the chart, and the 3rd copy is placed in the physician's hospital mailbox. The physician mailboxes are in a locked room, accessible by the physicians. As they are the only ones having access to their mailboxes, is this practice acceptable to meet our obligation of getting the information to the next level of care provider? Any patient without a physician on staff with a mailbox at our facility will have the information faxed to the next level of care provider, with the transmission receipt placed on the medical record. Also, is there any concern of privacy violation when faxing parts of the medical record without written patient consent, or is the assumption that all patients are being consented prior to discharge when the fax process is utilized? The other issue we had with faxing is ensuring the accuracy of the fax numbers, and verification that (even though we have a transmission receipt) the physicians are actually in receipt of the record.

HFAP is not prescriptive in how the communication of the discharge documents are communicated with the primary care physicians. In response to the question regarding the physician mailboxes, you would also need to consider how often those mailboxes are checked; can you verify that the information has reached the physician? Point to consider: in most instances, a single, consistent process creates less opportunity for error. When multiple processes are put into place, in order to accomplish the same outcome, invariably, there will be issues.

To the second question, hospitals should never assume that it's ok to share a patient's healthcare information. There should be proper consent obtained, as in any other case where information would be shared with the primary care physician.

16. What type of documentation is required for "assessing the patients' understanding of the discharge plan in their own words (#10)?

The assessment of the patients' understanding of the discharge plan in their own words would be akin to documentation found regarding other education which is provided to the patient/significant others throughout the hospital stay. For instance, it may be adequate to use a statement such as: "Provided discharge plan education - Patient verbalizes understanding in own words." Or "Provided education on insulin self-administration – Patient able to return demonstrate proper technique." These statements are not all-inclusive and should be made according to the level of understanding and ability to demonstrate appropriate techniques/understanding when applicable. There may be times when reinforcement is necessary and it would be expected that this would be documented appropriately, as well.

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17. Must the 3-day call back be completed by an R.N.?

YES. Standard 15.06.17 states the following: "It is not mandatory that the bedside RN make the follow-up patient phone calls. However, this individual should be an RN with experience, knowledge and training to recognize potentially emergent situations when speaking with the patient." The intent of these statements is to make sure that the facility understands that it is not exclusively expected that the bedside RN make these phone calls. However, the expectation is that it is an RN with the qualities described within the standard.

18. Does the follow up discharge telephone have to be a permanent part of the patient chart?

YES. Patient encounters should be made part of the permanent medical record. The purpose of the 'call-back' is to ascertain whether or not significant aspects of the patients medical needs are being met. The content of these discussions should be documented. During the conversation, items such as, the patient stating they "didn't like Nurse Suzy" would not be expected to be included in this documentation. Specific patient complaints gathered during this process should be taken care of through the facility's normal complaint process.

19. What do we do with AMA patients? Many are readmitted.

Currently, the discharge standards only relate to inpatients being discharged from the hospital. You should continue to follow your policy and procedure regarding the handling of AMA patients. However, you may apply these standards to AMA patients or other patient groups as your hospital deems prudent.

20. Any suggestions to streamline process for primary care physicians, without flooding them with phone calls or faxes?

We suggest that you make these process improvements a collaborative change. Hospitals should engage their Medical Staff in the implementation of the standards and work together to find a method of compliance which is beneficial to all stakeholders involved.

21. What is the preferred way to transmit discharge summaries to primary care physicians?

HFAP is not prescriptive as to the method of communication that must be used. Every facility has varying workflows and resources. Hospitals, in collaboration with their Medical Staff committee, have the authority to decide the most effective and efficient method of communicating with the primary care physician.

All standards interpretation inquiries should be submitted to info@hfap.org .