

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 1  
(I-20)

Introduced by: Doug Morrell, MD

Subject: Discharge Summary Reform

Referred to: OMSS Reference Committee  
(TBD, Chair)

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1 Whereas, Our ability to do complicated surgical and medical procedures is unprecedented, with  
2 the aid of electronic medical records our ability to produce a logical, concise, and accurate  
3 discharge summary has deteriorated to the point of nonexistence; and  
4  
5 Whereas, Current discharge summaries can be over 100 pages long and contain a multitude of  
6 completely unnecessary information; and  
7  
8 Whereas, Incomprehensible, bloated discharge summaries are a significant patient hazard  
9 since physicians resuming care of the patient find it nearly impossible to determine discharge  
10 diagnosis, hospital course, procedures performed, medications prescribed, or follow-up care;  
11 and  
12  
13 Whereas, All medical students and residents have been taught how to dictate and produce a  
14 discharge summary in their training which includes discharge diagnosis, procedures performed,  
15 hospital course, pertinent lab and radiology findings, discharge medications, and follow-up care;  
16 and  
17  
18 Whereas, All the equipment to produce a competent discharge summary is currently in place  
19 since surgeons still use the equipment to produce an operation note; therefore be it  
20  
21 RESOLVED, That the American Medical Association coordinate with the American Hospital  
22 Association to revive the concise dictated (or use of Dragon) discharge summary that existed  
23 prior to electronic medical records for the sake of much improved patient care and safety.  
24 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 9/14/2020

**RELEVANT AMA POLICY:**

**Hospital Discharge Communications H-160.902**

1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
  - a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
  - b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
  - c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
  - d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
  - e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
  - a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
  - b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
  - c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
  - d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

## **Evidence-Based Principles of Discharge and Discharge Criteria H-160.942**

- (1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
- (2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
- (3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
- (4) The AMA promotes the local development, adaption and implementation of discharge criteria.
- (5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
- (6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
- (7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
  - (a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
  - (b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
  - (c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the

family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

Citation: CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16

#### **Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965**

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

Citation: BOT Rep. 58, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Modified: CMS Rep. 01, A-16; Reaffirmed: I-18

## ONLINE FORUM TESTIMONY:

Here, here!! Vote FOR this one, too!!

*Lawrence Monahan, MD*

*Personal opinion*

Support useful, timely discharge summaries. Patients deserve this. It is a quality of care issue.

Indiana OMSS supports

*David Welsh, MD*

*Personal opinion*

Here we go again. Afraid this resolution, while true and well written, old easily be placed on the re-affirmation calendar. Existing policy covers this subject pretty well. Another example of good policy put on a shelf and not acted upon. The EMR is not our friend. Will support this resolution if it gets to the HoD.

*Jay Gregory, MD*

*Personal opinion*

I agree with Dr Gregory that this may well end up on the reaffirmation calendar. I would urge amending it with an action item to it does not just sit on the shelf.

*Kenneth Crabb, MD*

*Personal opinion*

Approve! DC summaries need to be much more concise – certainly for medical, surgical and surgical subspecialty inpatient admissions, but also summaries of emergency department visits. A 30 min sore throat ED visit can result in 100 pages of redundant, unnecessary information to shift through before getting at the "meat" of the visit! Complete waste of a lot of people's time, let alone the paper if one has to print these out. Need JCA (regulatory) and Legal (in case of malpractice and necessity of case review) opinions on this issue, which contributes to physician burnout.

*Theodore Christopher, MD*

*Personal opinion*

A plethora of data impedes meaningful communication. The only ones likely to read the whole electronic summary are prosecuting attorneys.

*Douglas Myers, MD*

*Personal opinion*

This is noble and needed, but reaffirmation. "2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care."

*Lee Perrin, MD*

*Personal opinion*

I agree with the consensus opinion that something needs to be done to stop the avalanche of extremely wordy and lengthy discharge materials. I am receiving 40 plus pages from hospitals, Urgent Care Clinics and even Drug Store clinics that have very little useful information. Most of it is cut and pasted from the EMR. A concise summary of what happened to the patient and an accurate medication list is all we need. We go through reams of paper every day most ended up shredded. This is a new resolution that is not covered by the existing AMA policies.

*Edward Bush, MD  
Personal opinion*

The origin of the problem is not so much the EHR - which, admittedly, \_enabled\_ the dysfunctional note system, including discharge summaries. It was Medicare bullet point systems for level of care. However, the ability to copy records from one note to the other decades ago was actually against regulations, and subject to discipline. Ironic that later regulations spawned a monster, a 'Sorcerer's Apprentice' of words in no particular format.

As a consultant, I spend inordinate amounts of time looking through old records, since no one else seems to, by the 'telephone' like promulgation of omissions and alterations over the years. It is made more difficult insofar as each author can define where any new information is placed within the record. It often is two or three sentences in a 10-page note, and well identified as the new, interval information. I was recently informed that EPIC has a specific switch which can dim out cloned/copied material... helpful, but not the entire answer.

At least discharge summaries should be in a readily informative format, as well as content. Perhaps the way to get around the existing policy, which I agree is a basis for reaffirmation as Dr. Perrin identifies, is to specify in the current resolution that, if a note or discharge summary is more than two pages, it must a) begin with an abstract of not more than a paragraph of 10 consecutive sentences, and perhaps b) be in a defined format, at least within an institution (if not, indeed, universal).

I realize this may be too prescriptive, but that kind of specificity might take hold and drive more appropriate wording that is more pointed than existing policy and so add to our policy body. It is my understanding that Medicare will be relaxing the requirements of what must be in at least follow up note,s to require only new information be present, which could remove some of the impetus for over-inclusive notes that get lost in themselves. I fear, however, that the grotesque overinclusive record is a bad habit that may be hard to break.

What therefore makes this resolution timely is that we must impel the AMA to take an active role in publicizing to the medical profession that it will be all right to write more directly relevant, communicative notes. (Perhaps one could include a Resolved that directs the AMA to engage with CMS to assure that they can agree to that.) The Titanic could not be stopped within 1/4 of a mile. Hence, we should start right now to try to reverse the counterproductive insanity of the current medical record.

*Matthew Gold, MD  
Personal opinion*