AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Discharge Summary Reform

Referred to: Reference Committee G

Whereas, Our ability to do complicated surgical and medical procedures is unprecedented, with
the aid of electronic medical records our ability to produce a logical, concise, and accurate
discharge summary has deteriorated to the point of nonexistence; and

Whereas, Current discharge summaries can be over 100 pages long and contain a multitude of
completely unnecessary information; and

Whereas, Incomprehensible, bloated discharge summaries are a significant patient hazard
since physicians resuming care of the patient find it nearly impossible to determine discharge
diagnosis, hospital course, procedures performed, medications prescribed, or follow-up care;
and

Whereas, All medical students and residents have been taught how to dictate and produce a
discharge summary in their training which includes discharge diagnosis, procedures performed,
hospital course, pertinent lab and radiology findings, discharge medications, and follow-up care;
and

Whereas, All the equipment to produce a competent discharge summary is currently in place
since surgeons still use the equipment to produce an operation note; therefore be it

RESOLVED, That our American Medical Association coordinate with the American Hospital
Association with input from the Centers for Medicare & Medicaid Services and other
professional organizations as appropriate to revive the concise discharge summary that existed
prior to electronic medical records for the sake of much improved patient care and safety
(Directive to Take Action); and be it further

RESOLVED, That our AMA internally develop a model hospital discharge summary in such a
manner as to be concise but informational, include to promote excellent, safe patient care and
improve coordinated discharge planning. This model use shall be promoted to our AMA and
Federation of Medicine colleagues. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 03/17/22
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.
Citation: CMS Rep. 07, I-16

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.


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