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Providing patient-centered enhanced discharge planning and rural transition support: Verifying discharge orders during rural transitions

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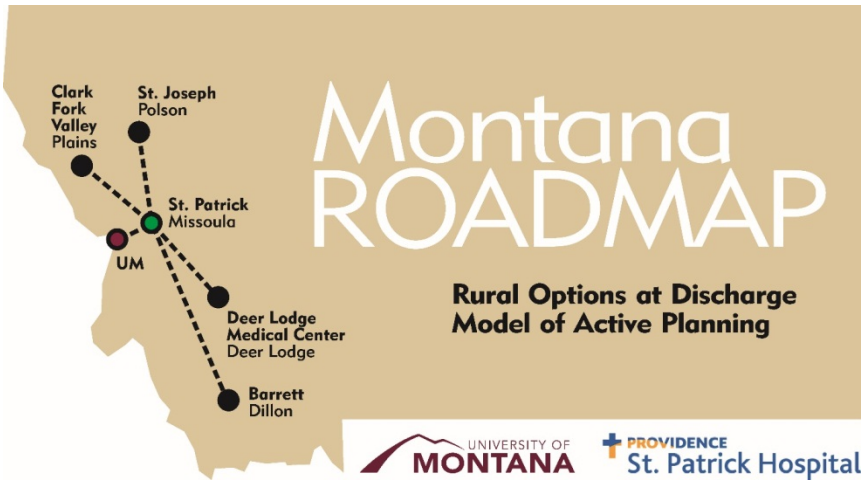
PROVIDING PATIENT-CENTERED ENHANCED DISCHARGE PLANNING AND RURAL TRANSITION SUPPORT



Verifying Discharge Orders during Rural Transitions

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In Collaboration with

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This document is a brief practice guide. It describes one component of a comprehensive program of enhanced discharge planning and rural transition supports.[1] As such, it is designed to be used as part of that program but can be used independently by others, as well.

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[1] Seekins, T., Boehm, H., Wong, J., Yearous, L., & Smith, A. (2017). *Providing patient-centered enhanced discharge planning and rural transition support: Building a rural transitions network between regional referral and critical access hospitals*. Missoula, MT: Rural Institute on Inclusive Communities, University of Montana.

Verifying Discharge Orders during Rural Transitions

Patients typically leave a hospital with numerous tasks that need to be performed in order to complete their treatment successfully. For example, they may need to fill both new and old prescriptions. They may need to perform specific self-care tasks, such as changing a dressing. And they may be expected to both limit some types of activities (e.g., lifting nothing above 10 lbs.) but engage in others (e.g., stretching or walking). These tasks are generally discussed with a patient before they leave the hospital, and they are typically summarized in the discharge plan or an after visit summary.

The discharge process is designed, in part, to describe the services a patient needs to secure or the tasks they need to perform in order to complete treatment and promote recovery once he or she gets home. Many of the orders or services planned should be implemented immediately or soon after discharge to be useful. Some involve additional medical treatment. Others may involve starting long-term services that address chronic conditions.

This process also transfers the responsibility for managing these treatments, services, and activities away from the hospital and to the patient. This shift of responsibility is one of the points at which treatment errors may occur. For example, in one case, a patient treated for Anasarca, sick sinus syndrome and thyroid abnormality at a regional referral hospital was discharged with an order for home oxygen. In checking with the patient on a Friday, three days after discharge, a Local Community Transition Coordinator (LCTC) learned that the oxygen order had not been filled. The patient had understood that the hospital staff had arranged for the delivery of the oxygen from a local provider. In checking with the local provider, they reported that they had not received any order. The LCTC was able to connect with the treating physician, secure an order, and the oxygen was delivered. Identifying this gap likely prevented serious consequences, including re-hospitalization.

In this delicate transition, hospital staff may not convey the orders clearly or may not complete tasks. A patient preparing to leave the hospital may have limited time to follow the description or not be responsive to the staff. The patient may simply forget the information provided or misunderstand it. Written information may be difficult to read (e.g., small print, dense wording). Similarly, providers referenced in the plan may misunderstand, misinterpret, or simply forget. Accordingly, there is a need for methods to increase the likelihood that these orders are filled and needed treatments are completed. One approach is to monitor the implementation of these components of a discharge plan.

Verifying Discharge Orders

An early step in providing rural transition support is to ***verify discharge orders***. This involves reviewing the patient's medical record (e.g., after visit summary in Epic®) to identify specific orders for treatments or services and then checking with the patient to ensure those are filled.[2] Figure 1 presents a form to record orders for a patient and serves as a checklist to verify them.

In general, staff should review the patient's discharge plan or after visit summary. Make notes of any physician orders or provider recommendations. Note them by circling "Yes" when a listed item has been ordered or completed or "No" if it has not. There is additional space to write in other, less typical orders. When contacting the patient to schedule a Transition Conference, summarize orders and ask if they have received the recommended services. If the patient indicates that he or she has not received an

[2] For the Montana ROADMAP project, these duties were completed by the LCTC. We suggest they now be transferred to the staff at the regional referral hospital (e.g., Research Transition Coordinator).

ordered service, explore the reasons and probe to see if the patient may need assistance with the issue. In this example, the patient reported that he had filled his prescription for a new medication, Atorvastatin. He had an appointment with his PCP that had not yet been held but it was scheduled. The LCTC noted that an order for oxygen had not yet been delivered.

	Ordered (Are any of the following ordered as part of the discharge plan?)	**Received** (Has the patient received the ordered services?)	**Notes**
Medications	(Yes) No	(Yes) No	Atorvastatin 80mg
Oxygen	(Yes) No	Yes (No)	Scheduled to be delivered
Home Health Care	Yes (No)	Yes No	
Durable Medical Equipment	Yes (No)	Yes No	
Home Modification	Yes (No)	Yes No	
Follow-up Appointment	Yes (No)	Yes No	
Local PCP Appointment	(Yes) No	Yes (No)	
Rehabilitation Appointment	Yes (No)	Yes No	
Other:	Yes No	Yes No	
Other:	Yes No	Yes No	

Figure 1: Sample Discharge Orders Verification Checklist. This example displays three discharge treatments or services identified by the LCTC for this patient.

Additional Issues

Physicians and other hospital staff typically give patients verbal and written information about a patient's treatment and recovery, instructions about medications and self-management, as well as specific orders and referrals. Despite these efforts, many patients in our research reported they left the hospital without a clear understanding of their recovery or of how to care for themselves as they recovered. Accordingly, we recommend that transition staff probe patients about these topics (see Figure 2). We suggest the following two questions shown in Figure 2. If a patient rates a question "2" or lower (i.e., Not Confident), you may want to review their discharge summary with them or put them in touch with the provider who can improve understanding of discharge instructions.

Issue	Not Confident				Very Confident	
1. It is important that you give yourself time to heal and recover from treatment. How confident are you that you understand the course of your recovery and when you can begin to return to routine activities?	0	1	2	3	(4)	N/A
2. Your medical team counts on you to manage many basic self-care tasks related to your treatment. For example, your physician may want you to take certain medications on a strict schedule or want you to avoid strenuous activity. How confident are you that you understand what you need to do and how to care for yourself as you recover?	0	(1)	2	3	4	N/A

Figure 2: Two recommended questions for probing a patient's understanding of their course of recovery and their responsibilities in managing their health.

Evaluation of the Discharge Orders Verification Checklist for Rural Transitions

The use of this checklist was evaluated as part of the Montana ROADMAP project. Local Community Transition Coordinators who used the checklist reported that it provides a simple structure for performing an important service for patients. Table 1 below shows the number of orders made and filled for 34 patients in our research study. Over 90% of discharge orders were filled but nine were not. One of the orders not filled involved home oxygen for a patient who was treated for a cardiac condition presented in Figure 1. While few issues were missed, gaps that were identified and addressed may have prevented potentially serious consequences. Verifying that a patient is getting the treatment and support expected may improve treatment outcomes and reduce hospital readmissions.

Table 1
Discharge Orders Made and Filled

Orders	Made	Filled	Percent
Home Health	4	4	100%
Durable Equipment	7	7	100%
Follow-ups	25	25	100%
PCP Appointments	12	12	100%
Other 2	1	1	100%
Medications	30	27	90%
Other 1	7	6	86%
Rehab Appointments	12	8	67%
Oxygen	1	0	0%
Home Modifications	1	1	0%
Total	**100**	**91**	**91%**