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EDITORIAL

Timely Discharge Communication: Just the Fax?

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In July 2003, as a fresh intern, I was introduced to care transitions and our tool for information transfer at hospital discharge—the fax machine. After writing our discharge order and discharge prescriptions, the team would compose the discharge summary and transmit the document via fax. I asked my resident where these faxes were going, because they were all sent to the same number in the hospital. Humorously, he did not know. Summaries were completed within days, or sometimes weeks, of discharge and faxed to a mysterious destination for filing and presumably for dissemination to outside providers. The message was clear to me that discharge summaries were not very useful or important, and they were definitely not seen as a critical part of the care-transition process.

This attitude toward the discharge summary is not surprising. Historically, when physicians cared for their patients prior to, during, and after hospitalization, the goal of the discharge summary was to document patients' care for hospital records. It was not critical as a communication tool unless a patient was being transferred to another healthcare facility and a new care team. However, that all changed with decreasing hospital length of stay, the contemporaneous rise in post–acute care discharges, the rise of the hospitalist care model, and the resulting transition of care from hospitalist to outpatient physician. Clear, rapid completion and communication of discharge summaries became essential for safe transitions in care.

The lack of focus on the discharge summary as a communication tool is reflected in regulations and standards of accreditation bodies. In 1986, the Medicare Condition of Participation required that inpatient records be completed within 30 days of discharge. Despite all of the changes in healthcare, the 30-day requirement for discharge summary completion has persisted, often as a medical staff requirement. Similarly, The Joint Commission requires that discharge summaries include 6 components (reason for hospitalization, findings, treatment provided, discharge condition, instructions, and physician signature) but does not provide a timeframe. As a result of this lack of emphasis on timely completion of discharge summaries, studies have shown that although summaries usually include core elements, they are not completed in a timely fashion. Consequently, most post-discharge visits occur without the benefit of a discharge summary.[1] The most complex patients, who ideally are seen within a few days of discharge, are the least likely to have received the discharge summary at the first postdischarge visit.

Although it seems intuitively obvious that more timely communication of discharge summaries should lead to better outcomes, especially lower readmission rates, few studies have examined this issue, and the findings have not been consistent.[2–5] Is it possible that physicians and other members of the healthcare team often communicate with each other through telephone calls and text messaging, especially about the sickest patients? If so, timely discharge summaries could have a small marginal effect on outcomes. Therefore, the study in this issue of the *Journal of Hospital Medicine* by Hoyer and colleagues is a welcome addition to the literature.[6] They found that discharge summary completion 3 or more days after discharge was associated with an adjusted odds ratio of 1.09, and the odds ratio increased with every additional 3-day delay in completion.

It is possible that the analysis by Hoyer et al. underestimated the benefit of timely discharge summaries. To achieve full benefit, the discharge summary must be completed, accurately delivered, read by the receiving provider, and used at the first follow-up visit. Their claims-based analysis did not contains these latter elements, which would bias their results toward the null hypothesis. Future studies should examine how receipt of a summary, as opposed to transmission, is associated with postdischarge outcomes.

In subgroup analyses, no associations between discharge summary timeliness and readmissions were found for patients cared for on the gynecology-obstetrics and surgical sciences services. Although caution is always needed when interpreting subgroup analyses, it is possible that the lack of association is attributable to the relatively acute conditions of many patients on these services, the relative provider continuity that persists in surgical disciplines, or whether these disciplines use other means of communication more frequently (eg, postdischarge phone calls among providers), mitigating

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the impact of the written discharge summary. Additional studies are needed to examine these issues. In addition, studies should examine how community or social factors might attenuate the benefit of timely communication, and explore the effect of discharge summaries on outcomes for patients admitted to an observation level of care, which is increasingly common and for which discharge summaries are less likely to be required.

The findings of the study by Hoyer et al. support proposed federal legislation—the Improving Medicare Post-Acute Care Transformation Act of 2014. The proposed rule for discharge planning would change the Medicare Conditions of Participation to require transmission of discharge information, including the discharge summary, within 48 hours of discharge (https://federalregister.gov/a/2015-27840A).[7] If enacted, this rule could substantially improve the timely availability of discharge information following care transition.

Fortunately, the work of preparing and transmitting the discharge summary is already part of the physician workflow, albeit often delayed. This traditional means of communication could even remain unchanged in form, if the order of the workflow could be altered in terms of timeliness, and no additional work would be created. With the hospitalization fresher in memory at the time of discharge, work might even be reduced. This efficiency presents a reasonable and immediately actionable appeal to providers.

The challenge to providers and systems remains to refine the quality and efficiency of communication and to move health communication into the 21st century. Tremendous potential exists for interactive communication among providers at discharge, which will not only build the quality of information delivered, but possibly also the qualitative experience of communication, building relationships in our increasingly complex and fragmented delivery networks. This may be a disappointment to the manufacturers of fax machines, but it will be a welcome improvement for caregivers and patients.

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