APPENDIX

Appendix Table 1. Definitions for Abstracting Expert-Recommended Discharge Summary Components

Expert-Recommended Components	Consensus Definitions*
Patient's Medical Course	
Admission Date	Date at which the patient entered/was admitted to the hospital.
Discharge Date	Date at which the patient left/was discharged from the hospital.
Primary Diagnoses	Medical reason that the patient required hospitalization. The primary diagnosis the most important or dominant reason (if there is more than one).
Chief Complaint	Any description of the patient's primary presenting condition.
History of Present Illness	A description of a patient's initial presentation to the hospital admission including a description of the initial diagnostic evaluation.
Admission Physical Exam	A system-based physical description of the patient's status on presentation to the hospital. This does not have to be a complete exam to be considered to be present. A focused exam is acceptable.
Drug Allergies	A listing of any medication allergies a patient may have. Of note, if "No Known Drug Allergies" or "NKDA" is listed, the Drug Allergies section of the discharge summary is considered to be present.
Hospital Course	A description of the events occurring to a patient during his/her hospital stay.
Lab Results	A listing of the results of one or more laboratory tests performed during the hospitalization. The statement "no labs/laboratory results" would meet the criteria for this category being present. Of note, lab results may be found within the body of the hospital course section of the discharge summary. Pathology studies should be coded as a procedure, not as a laboratory.
Hospital Procedures	A description of all surgical, invasive, diagnostic or technical procedures a patient may have experienced as an inpatient (i.e., cardiac catheterization, video EEG, radiology [MRI, CXR, etc.], EKG, etc.). The statement "no procedures" would meet the criteria for this category being present. Of note, procedure descriptions may be found within the body of the hospital course section of the discharge summary. Pathology studies should be coded as a procedure.
Hospital Consults	A description of surgical, medical, other specialty or allied health consults a patient experienced as an inpatient or a specific statement that "no consults" occurred. Any notation of PT/OT (physical therapy/occupational therapy) working with the patient in hospital count as consults, even if the actual word 'consult' is not present.
Discharge Condition	Any documentation that gives a sense for how the patient is doing at discharge meets these criteria.

Appendix Table 1 (continued). Definitions for Abstracting Expert-Recommended Discharge Summary Components

Expert-Recommended Components	Consensus Definitions*
Complications	Anything that occurs as a result of being in the hospital and is not a pre-existing comorbidity and is not a direct result of the patient's primary disease course is a 'complication.' The statement "no complications" would meet the criteria for this category being present. Some examples of complications include: Acute interstitial nephritis (AIN), Acute tubular necrosis (ATN), Adverse drug effect, Anemia requiring transfusion, Aspiration pneumonia, Atrial fibrillation (new onset), Cardiopulmonary arrest, Cellulitis, Confusion, Delirium (post-operative or otherwise), deep venous thrombosis (DVT), Falls, Fluctuating levels of consciousness, GI bleed after starting heparin, Hyponatremia, Hypotension, ICU psychosis, Medication error, Oversedation, Pneumonia contracted while in hospital, Post-op blood loss requiring transfusions, Post-op hypoxemia requiring intervention, Respiratory failure, Small bowel ileus, Surgical/procedural complications, and Urinary tract infections.
Functional and Cognitive Ability at Discharge	
Cognitive Function on Discharge	A general description of a patient's cognitive abilities at the time of hospital discharge (e.g., patient remains confused, delirious, patient has returned to cognitive baseline, no cognitive deficits noted, patient cannot follow commands, etc.). Of note, cognitive function specifically pertains to documentation of the presence or absence of cognitive deficits—and does not merely include neurologic deficits (i.e. aphasia, apraxia, hemiparesis, etc.). If the patient's baseline cognitive status is recorded and then a statement is made to the effect that the patient's neurologic status is improved or stable, this criteria is considered to have been met.
Transfer Methods/Mobility Aids	A description of the patient's transferring ability or lack thereof (e.g., "walks unassisted," "ambulates with walker," "bed bound," etc.). This should be coded specifically on the basis of a patient's functional transferring ability. A sole listing of neurological deficits does NOT meet these criteria (as these deficits may or may not impact a patient's functional transferring ability) and this component should be coded as absent.
Activities of Daily Living (ADL) Abilities	A patient's ability to eat, bathe, dress, and use toilet on one's own. If a description of a patient's ability to perform any or all basic ADLs is included within the discharge summary, this component is considered to be present. Notation that patient is in "a totally dependent state" implies patient is unable to perform any ADLs and, therefore, meets criteria for documentation for this item. Note that for the purpose of this abstraction, transferring is not counted as an ADL since it is being abstracted separately above.
Fall Risk Status	If the patient's is noted as high fall risk, low fall risk, etc. within the discharge summary, and/or if "history of falls" or "recurrent falls" is noted in the patient's history of present illness or past medical history, this component is considered to be present. Simply being admitted for a fall without further mention of falls or fall risk is not sufficient.

Appendix Table 1 (continued). Definitions for Abstracting Expert-Recommended Discharge Summary Components

Expert-Recommended Components	Consensus Definitions*
Future Plan of Care	
Discharge Medication List	A listing of all discharge medications OR a statement noting that admission medications are unchanged AND a listing of admission medications OR a statement noting that admission medications are unchanged except for a specific number of medications AND a listing of the altered medications AND a listing of admission medications.
Diet	A listing of a patient's recommended dietary intake (i.e., general, dysphagia, renal, diabetic (ADA), no added salt (NAS), no concentrated sweets (NCS), etc.).
Activity Instructions	An order for a patient's activity level upon hospital discharge (i.e., "weight bearing as tolerated," "ambulate with walker," "bed rest," "general," etc.).
Therapy Orders	Orders for physical or occupational therapy present within the discharge summary OR a reason documented as to why this patient does not have such orders (i.e., "no therapy as patient is ___," "plans for future therapy after further recovery," etc.) OR a description/listing of specific therapy exercises prescribed (i.e., "bilateral upper extremity global conditioning exercises") would all meet criteria for this component being present. If no explicit therapy orders are listed in the discharge summary, mark this item as absent even if the patient is being discharged to inpatient rehabilitation.
Pending Studies	A specific listing of medical studies completed but requiring follow-up for final results at the time of hospital discharge (i.e., CT scans, echocardiograms, MRI, etc.). The statement "no pending studies" would meet the criteria for this category being present.
Pending Laboratory Tests	A specific listing of laboratory tests requiring follow-up at the time of hospital discharge (i.e., bacterial cultures, CBC, etc.). The statement "no pending lab tests" would meet the criteria for this category being present.
Goals/Preferences (Code Status)	A description of a Patient's Goals and Preferences (i.e., comfort care) or a specific listing of a patient's Code Status (i.e., full code, DNR, DNR/DNI) within the discharge summary is necessary to meet these criteria.
Communication of Prognosis/Diagnosis to Patient/Family	A Prognosis/Diagnosis is considered to have been documented as having been communicated to the patient, patient's surrogate (i.e., guardian) or family when a specific statement to this fact appears in the discharge summary (i.e., "is aware of the" prognosis/diagnosis," "the diagnosis was communicated to the patient," etc.).
Disposition	A specific notation of where the patient will be discharged to after hospitalization. A specific discharge site type (i.e., home, long-term care, etc.) or facility name listing is necessary to fulfill this category.
Whom Medical Follow-up is To Be With	A designation of a specific professional, professional type (i.e. neurologist), or clinic for medical follow up.

Appendix Table 1 (continued). Definitions for Abstracting Expert-Recommended Discharge Summary Components

Expert-Recommended Components	Consensus Definitions*
Timeframe for Medical Follow-up	A time period in which a patient is to be next seen by a particular provider (i.e. follow up within two weeks with PCP) OR a specific date/appointment for follow-up.
Name and Contact Information	
Primary Care Provider Name	A listing of the primary care providers name somewhere on the discharge summary. If no specific primary care provider's name is listed, but the discharge summary is sent to a group practice (i.e., Physicians Group), then consider this component as present.
Hospital Physician Name	The name of the physician or clinical provider who dictated the discharge summary.
Hospital Physician Contact Information	The telephone number and/or pager number of the physician or clinical provider who dictated the discharge summary. Alternatively, a telephone number and/or pager number for the primary inpatient health-care team leader could be provided.
Caregiver/Guardian Name	The name of a patient's primary caregiver, guardian, family member, or next of kin.
Caregiver/Guardian Contact Information	The telephone number and/or address of a patient's primary caregiver, guardian, family member, or next of kin.

*The abstraction should be performed from the point of view of a receiving provider who only has the discharge summary as a source of information. Therefore, sections should be marked as absent if the discharge summary notes "refer to [another] document" for information within a particular section. One mention of any criteria within a component description is sufficient to note that component as 'present' (i.e., for laboratory results, as long as one laboratory result is mention (even if more were completed) this component is to be marked as 'present').