BRIEF REPORT

Assessing Patient Readiness for Hospital Discharge, Discharge Communication, and Transitional Care Management

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Background: **Discharge communication between hospitalists and primary care clinicians is essential to improve care coordination, minimize adverse events, and decrease unplanned health services use. Health-related social needs are key drivers of health, and hospitalists and primary care clinicians value communicating social needs at discharge.**

Objective: **To 1) characterize the current state of discharge communications between an academic medical center hospital and primary care clinicians at associated clinics; 2) seek feedback about the potential usefulness of discharge readiness information to primary care clinicians.**

Design: **Exploratory, convergent mixed methods.**

Participants: **Primary care clinicians from Family Medicine and General Internal Medicine of an academic medical center in the US Intermountain West.**

Approach: **Literature-informed REDCap survey. Semistructured interview guide developed with key informants, grounded in current literature. Survey data were descriptively summarized; interview data were deductively and inductively coded, organized by topics.**

Results: **Two key topics emerged: 1) discharge communication, with interrelated topics of transitional care management and follow-up appointment challenges, and recommendations for improving discharge communication; and 2) usefulness of the discharge readiness information, included interrelated topics related to lack of shared understanding about roles and responsibilities across settings and ethical concerns related to identifying problems that may not have solutions.**

Conclusions: **While reiterating perennial discharge communication and transitional care management challenges, this study reveals new evidence about how these issues are interrelated with assessing and responding to patients' lack of readiness for discharge and unmet social needs during care transitions. Primary care clinicians had mixed views on the usefulness of discharge readiness information. We offer recommendations for improving discharge communication and transitional care management (TCM) processes, which may be applicable in other care settings. (J Am Board Fam Med 2024;37:706–736.)**

Keywords: **Communication, Discharge Planning, Patient Safety, Primary Health Care, Transitional Care**

Introduction

Communication between hospitalists and primary care (PC) clinicians (including physicians, nurse practitioners, and physician assistants) is essential after hospital discharge to improve care coordination, minimize adverse events, and decrease costs.[1] Review of discharge information is a core component of transitional care management

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(TCM), which is required by the Centers for Medicare and Medicaid to support patients' transitions from inpatient care back to home.[2,3] High quality discharge communication should include complete and timely information about primary diagnosis, diagnostic test results, treatment or hospital course, discharge medications, pending studies, patient and family counseling, and follow-up plans.[4] Despite increasing access to inpatient hospital data through shared electronic health records (EHRs), PC clinicians do not always have access to complete and timely hospital discharge summaries.[5–8] Further, hospitalists and PC clinicians note the importance of including social information in discharge communication,[9] which is now reinforced by recent US federal policy encouraging inpatient screening for health-related social needs.[10]

In our ongoing research on improving discharge processes, we asked that the Readiness for Hospital Discharge Scale (RHDS)[11–13] be completed by discharging patients, inpatient registered nurses (RN), and, when possible, family caregivers on the day of discharge. The RHDS assesses perceptions of discharge readiness across 4 domains: Personal Status (how the patient feels on day of discharge), Knowledge (about self-care at home); Perceived Coping Ability; and Expected Support (how much social or caregiving support the patient will have). The RHDS is a validated measure which has demonstrated a positive predictive value of identifying patients at risk for adverse postdischarge outcomes, such as readmission.[11,12] (Appendix 1 has additional details about the RHDS.)

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This study was approved under Exemption 2 by the University of Utah Institutional Review Board (IRB# 00154704). Study risks and benefits were provided in writing prior to surveys and interviews, written consent was waived, and participants expressed consent by continuing with the survey or interview.

We used the COREQ checklist for reporting the qualitative elements of this mixed methods study.

The deidentified data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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The original purpose of this study was to: 1) characterize the current state of discharge communication between an academic medical center hospital and PC clinicians at associated clinics, and 2) seek feedback about the potential usefulness of discharge readiness information to PC clinicians. Additional aims of this manuscript include describing unexpected inductive, but strongly interrelated, topics that emerged from the data, including PC clinician views on: a) inadequate TCM processes and hospital follow-up appointments, b) concerns about lack of shared understanding between hospital and PC teams and ethical concerns related to lack of available resources, and c) specific recommendations for improving discharge communications.

Methods

Study Design

We used an exploratory, convergent mixed methods design, using an investigator-developed survey and semistructured interviews with the purpose of using interviews to clarify and expand our understanding of survey data. This study was approved by the University of Utah Institutional Review Board (IRB# 00154704). Recruitment and research participation was completed June-July, 2022.

Sample

The study team recruited Family Medicine (FM) and General Internal Medicine (GIM) PC clinicians at an academic medical center of the intermountain United States. The study team invited participation during faculty meetings, then emailed the survey to all faculty in each division (FM n = 36; GIM n = 20; Total = 56). A second invitation was emailed approximately 1 week later. Survey respondents indicated willingness to participate in an interview.

Survey

The 94-item electronic REDCap[13,14] survey (Appendix 2) was informed by a literature review.[15–17] This manuscript reports survey responses in these domains: individual and practice characteristics (items 3 to 9); discharge communication received directly from a hospital care team member versus communication sent automatically through the EHR (items 18 to 28); and specific feedback on the RHDS (items 62 to 84). To ensure

anonymity, participant contact information was unlinked to survey responses.

Interviews

The interview guide was developed with input of key informants from the health system and current literature review.[15,17–19] The interview guide domains align closely with survey domains; domains and subdomains with definitions are provided in Appendix 3. The interview guide was iterated based on an ongoing review of survey responses and team debriefing after interviews. Probing questions were used to elicit more information about topics raised by participants not included in the original interview guide, particularly related to feelings about receipt and integration of social information. Interviews were conducted by phone or video conferencing, and were audio recorded, professionally transcribed, verified, and deidentified.

Data Analysis

Descriptive statistics were summarized using Stata/S.E. 17.0.[20] Qualitative data from open-ended survey responses and interview transcripts were analyzed using content and thematic analysis.[21,22] Initial deductive codes were derived from the original version of the interview guide. The first 2 interviews were coded in Microsoft Word simultaneously by 2 coders (CEE and ME), then discussed with a third (AAB). The remaining interviews were coded individually, then verified by a second coder. Inductive codes were iteratively added and discussed until agreed on. The team reached consensus as codes were grouped into topics using Microsoft Excel. Interview guide domains, subdomains with definitions, and codes are found in Appendix 3.

Data Integration and Rigor

Quantitative and qualitative data were compared and triangulated.[23] Peer debriefing was used to explore topics, interpretations, and biases. Member-checking occurred within and between interviews, and by sharing deidentified, preliminary results with FM and GIM divisions. The team agreed there was data saturation,[24] meaning no new topics emerged in the final interviews. Taken together, these considerations increase rigor, credibility, and trustworthiness of the data and interpretation.[23,25]

Results

Twenty-five surveys (44.6% participation rate) were completed. From these, 12 of the 25 respondents completed interviews. 3 surveys were started but not completed and were excluded from the analysis. Surveys took ~15 minutes; interviews lasted ~30 minutes.

Sample Characteristics

Participants were mostly physicians (84%), while the remaining were Nurse Practitioners or Physician Assistants. Of survey respondents (n = 25), 40% (n = 10) had been in their role for 1 to 5 years. Interview participants (n = 12) had practiced for a mean of 10 years (standard deviation [S.D.]=9.9; range 3 to 36 years). Interview respondents reported a mean panel size of 1187 patients (S.D. = 832, range 50 to 1700). Specific division information was only collected in interviews, where respondents were divided evenly between FM and GIM (50% each), representing 4 clinics, 2 from each division. Table 1 displays sample characteristics.

Key Topics

Two main topics emerged from quantitative and qualitative data integration representing the key experiences shared by participants and are presented below. Survey responses are summarized in Tables 2 and 3; interview topics and excerpts are found in Table 4.

Topic 1: Discharge Communication

The first topic includes findings related to a) views of current discharge communication between inpatient and PC settings, b) TCM and follow-up appointment challenges, and c) recommendations for improving discharge communication.

Overall, feelings about hospital discharge communication between inpatient and PC settings were mixed. Few respondents (8%, n = 2) state that they regularly (>50% of the time) receive direct discharge communication (Table 2). 16% (n = 4) reported never having received direct discharge communication. 48% (n = 12) of respondents said direct communication most often comes from the inpatient attending physician versus inpatient Case Manager (16%, n = 4) or other team member. Direct communication is most often received in an EHR in-basket message (per 20 of 21 [95%] of those who report receiving direct communication)

Table 1. Participant Characteristics

	Survey Participants (n = 25)	*n* (%)	Interview Participants (n = 12)	*n* (%)
Professional Role	Physician	21 (84%)	Physician	10 (83%)
	NP/PA	4 (16%)	NP/PA	2 (17%)
Age (by category)	Not asked		31 to 45	11 (92%)
			≥46	1 (8%)
Gender	Not asked		Women	7 (58%)
Ethnicity	Not asked		Not Hispanic	11 (92%)
			Declined to respond	1 (8%)
Race	Not asked		White	11 (92%)
			Declined to respond	1 (8%)
Years in current role	<1 year	3 (12%)	Mean (years)	10
	1 to 5 years	10 (40%)	Min-Max	3 to 36
	6 to 10 years	5 (20%)	S.D.	9.9
	>10 years	7 (28%)	Missing	2 (17%)
Hours spent seeing patients	Monthly		Weekly	
	9 to 12 hours/month	0	Average: 26.5 hours/week Min-Max: 15 to 32 hours/week S.D.: 6 hours/week	
	22 or more hours/month	22 (100%)		
Number of patients on clinician panel	≤99	0	(n = 8) numerical responses Average: 1187.5 patients Min-Max: 50 to 1700; S.D.: 832	
	100 to 299	7 (28%)		
	300 or more	18 (72%)		
Division	Not asked		Family Medicine	6 (50%)
			General Internal Medicine	6 (50%)

Note. All physicians were Medical Doctors.
Abbreviations: NP, nurse practitioners; PA, physician assistants; SD, standard deviation.

versus phone call. Satisfaction with current discharge communication was low to neutral, with 32% (n = 8) dissatisfied/very dissatisfied and 56% (n = 14) responding neutrally (Table 2).

Most (68%, n = 17) survey respondents reported receiving automatic discharge notifications most (75 to 100%) of the time (Table 2). However, 20% (n = 5) reported that notifications are frequently missing. Almost one-third (28%, n = 7) state they commonly (25 to 75% of the time) receive notifications for patients they do not know.

When notified of a hospital discharge, participants said they respond in various ways ranging from deleting the message with no additional action, to contacting the hospital care team and/or patient, and coordinating postdischarge care with the clinic Care Manager. While survey respondents generally felt discharge notifications are Helpful (42%, n = 10) or Very Helpful (25%, n = 6), interviews revealed a range of positive and negative experiences (Table 4). Importantly, there was overwhelming consistency that discharge summaries are not completed/signed in a timely manner, resulting in having to search the EHR. Interviewees also noted variations in communication from hospitals within the region. Interoperability (ie, the Epic-specific 'Care Everywhere' function[26]) of regional hospital EHRs was mentioned positively (Table 4). One specific outside hospital was noted as having clear, brief discharge summaries and clinicians who make direct contact.

An unexpected finding emerged from the interviews centered around current TCM process, including hospital follow-up appointments. PC clinicians knew of an existing process to support transitions from hospital to PC. However, they could not describe what this involved, which patient population(s) it reaches, or which department was "in charge" (Table 4).

In addition, PC clinicians described 2 important challenges related to hospital follow-up appointments (Table 4). First, patients leave the hospital with no follow-up scheduled. Second, clinics lack dedicated TCM appointments reserved for hospital follow-up. PC clinicians also recognize important challenges with some patients who need optimal

Table 2. Primary Care Clinician Survey Responses Related to Current Discharge Communication Received

Direct Discharge Communication	n = 25* (%)
How often do you receive direct [non-automated] communication from the inpatient team at discharge?	
0 to 25%	19 (76%)
26 to 50%	4 (16%)
51 to 75%	1 (4%)
76 to 100%	1 (4%)
When direct contact is received, who do you receive contact from most often?	
I have never received direct communication	4 (16%)
Inpatient attending physician	12 (48%)
Inpatient Case Manager	4 (16%)
Inpatient resident physician	2 (8%)
Inpatient APC	1 (4%)
Other	2 (8%)
Addiction medicine team Pharmacist assisting in transitions of care	
When direct contact is received, what is the most common communication method? (*n = 21)	
In-basket message in Epic	20 (95%)
Phone call	1 (5%)
How satisfied are you with communication between inpatient providers and you as primary care provider at time of discharge?	
Very Dissatisfied	2 (8%)
Dissatisfied	6 (24%)
Neutral	14 (56%)
Satisfied	3 (12%)
Very Satisfied	0 (0%)
Automatic Discharge Communication through the Electronic Health Record	**n = 25 (%)**
When automatic discharge notification is received, how often is the discharge summary attached?	
0 to 25%	3 (12%)
26 to 50%	2 (8%)
51 to 75%	5 (20%)
76 to 100%	15 (60%)
How many of your primary care patients have been discharged from the University Hospital in the last year?	
None	0
1 to 5	0
6 to 10	5 (20%)
11 to 20	5 (20%)
21 or more	15 (60%)
How often [what percentage of the time] are you getting automatic notifications of your patients' discharge through Epic?	
0 to 25%	1 (4%)
26 to 50%	3 (12%)
51 to 75%	4 (16%)
76 to 100%	17 (68%)
When you are notified of a patient discharge [automatically] through Epic, how often do you recognize the patient as a patient you know well and consider to be "your" patient?	
0 to 25%	1 (4%)
26 to 50%	3 (12%)

Continued

Table 2. Continued

Automatic Discharge Communication through the Electronic Health Record	n = 25 (%)
51 to 75%	4 (16%)
76 to 100%	17 (68%)
How helpful do you find [automatic] discharge notifications?	
Very Unhelpful	1 (4%)
Unhelpful	4 (17%)
Neutral	3 (12%)
Helpful	10 (42%)
Very Helpful	6 (25%)
What do you do when you receive an automatic discharge notification?(Sample of representative survey responses)	
• "'Done' the message so it goes away. I typically get at least 3 other notifications of their stay with more relevant information." SP 2	
• "I sometimes look at the HPI/ED note to see why, but often I do nothing." SP 3	
• "Mostly delete unless it's a patient with special needs then I reach out to primary team." SP 5	
• "If it is a patient with chronic issues requiring complex management, I follow the hospital care daily. Rarely, I send the hospital care team Epic messages regarding the patient's previous care and medical events. I alert our Care Managers if it appears that the patient will need ongoing care coordination post discharge." SP 28	

Note. *Sample size and corresponding percentages differs as noted.
Abbreviations: SP, survey participant; APC, advanced practice clinician, inclusive of nurse practitioners and physician assistants; HPI, history of present illness; ED, emergency department.

continuity of care, including those who are frequently hospitalized.

PC clinicians had specific recommendations for improving discharge communications, saying discharge summaries should be timely and brief, and include a) reason for admission; b) implications for outpatient care, particularly rationales for changing medications; and c) an actionable to-do list. Finally, PC clinicians recognized that direct messages from the inpatient team would be ideal, but not always realistic (Table 4).

Topic 2: Usefulness of the RHDS in the Outpatient Setting

The second topic focused on the usefulness of the RHDS in PC settings. Participants highlighted concerns regarding a lack of shared understanding about roles and responsibilities across settings and ethical concerns related to identifying problems that may not have readily available solutions. In surveys, 52% (n = 13) said they wanted to receive the RHDS from *at least 1 perspective* (that is, patient, inpatient RN, or family caregiver) (Table 3). Almost half said that they would like to receive the patient's RHDS (46%), and inpatient RN's RHDS (44%) (Table 3). Of those, most wanted it in the discharge summary (Table 4).

When asked to share thoughts on why they did not want to receive this information (Table 3), respondents were concerned that issues identified by the RHDS should be addressed *before* the patient is discharged; that the information would not affect their clinical decision making; that they lacked adequate resources to address identified issues; and that they already felt overloaded with "*too much information*" (*Survey Participant* [SP] 5).

Still, many PC clinicians saw the value in completing the RHDS before discharge. Moreover, respondents said that if the RHDS score indicated the patient was at "high-risk" for unplanned readmissions, it could trigger specific action (Tables 3 and 4). For example, if the inpatient RN had concerns, the PC clinician would "*expedite follow-up and potentially set up services* prior to *follow-up*" *(SP 1).*

In addition, PC clinicians expressed concerns of a lack of shared understanding about roles and responsibilities across settings, and their sense that they are left to handle social circumstances for which they have no resources (Table 4). PC clinicians also raised ethical concerns stemming from assessing problems that may not have readily available solutions either inside the health care system, or through community resources, particularly if a patient's lack of discharge readiness is related to unmet social needs (eg, transportation, food, housing). In particular, this lack of resources includes understaffing in key interdisciplinary roles which

Table 3. Survey Respondent Perspectives About Receiving the Readiness for Hospital Discharge Scale (RHDS)

Topic	Survey Response	n = 25 (%)
Percentage who would like to receive the RHDS from at least one perspective (i.e., inpatient Registered Nurse, patient, or caregiver)	Yes	13 (52%)
	No	12 (48%)
Would you like to receive this from the inpatient Registered Nurse at the time of Discharge?	Yes	11 (44%)
	No	14 (56%)
If yes (n = 11), How?	Include in discharge summary	8 (73%)
	By Epic in-basket message	3 (27%)
	By email	0
	Other	0
If yes (n = 11), When?	Before discharge	1 (9%)
	The day of discharge	6 (55%)
	Before their next appointment	4 (36%)
	Other	0
If yes (n = 11), What action would you take if you found out that the inpatient Registered Nurse had concerns about the patient at the time of discharge?	• "Contact social work and care management. Change follow-up appointment if needed (like to address transportation issue)." SP 21 • "I would want direct contact, through Epic, and would want [the inpatient team] to be sure the patient has been scheduled for follow-up." SP 27 • "I would wonder why the patient was being discharged to a potentially unsafe environment. If the RN has concerns, it seems that it creates patient safety and system liability issues to discharge the patient without addressing these concerns with specific actions." SP 28	
If no (n = 14), Please share your thoughts on why you do not want to receive this information from the Registered Nurse's perspective.	• "We in primary care are overburdened with notifications, without a system that rewards out of office care. The University is already working on reducing MyChart messages, so increasing it would be counterproductive. Additionally, I'm not sure how receiving this information will change clinical decision making, or requires physician input in changing clinical decision making." SP 2 • "What support/resources do I have to help them once we identify these needs?" SP 9	
Would you like to receive this from the Patient at the time of Discharge?	Yes	11 (46%)
	No	13 (54%)
If yes (n = 11), How?	Include in discharge summary	9 (82%)
	By Epic in-basket message	2 (18%)
	By email	0
	Other	0
If yes (n = 11), When?	Before discharge	1 (9%)
	The day of discharge	8 (73%)
	Before their next appointment	2 (18%)
	Other	0
If yes (n = 11), What action would you take if you found out that the Patient had concerns about the patient at the time of discharge?	• "Get in touch with [the patient] to see if additional services could be of use. As well as expedite follow-up." SP 1 • "Follow-up via telephone or other methods within 1 to 2 days post-discharge." SP 23 • "Try to address their concerns at their follow-up appointment, and reach out to inpatient team to help address issues before discharge." SP 22	
If no (n = 13), Please share your thoughts on why you do not want to receive this information from the Patient's perspective.	• "These seem mostly like items that should be addressed by the inpatient team before discharge." SP 24 • "It won't change my management post-discharge." SP 11	

Continued

Table 3. Continued

Topic	Survey Response	n = 25 (%)
Would you like to receive this from the patient's caregiver (unpaid family member or friend) at the time of Discharge?	Yes	9 (36%)
	No	16 (64%)
If yes (n = 9), How?	Include in discharge summary	7 (78%)
	By Epic in-basket message	2 (22%)
	By email	0
	Other	0
If yes (n = 9), When?	Before discharge	1 (11%)
	The day of discharge	6 (67%)
	Before their next appointment	2 (22%)
	Other	0
If yes (n = 9), What action would you take if you found out that the patient's informal caregiver (unpaid family/friend) had concerns about the patient at the time of discharge?	• "Mobilize additional services if needed." SP 18 • "Closed loop communication, via Epic." SP 29 • "Have Care Manager contact care giver to see if we can coordinate needed support (though it seems like this should be done by hospital care team)." SP 28	
If no (n = 16), Please share your thoughts on why you do not want to receive this information from the patient's informal caregiver (unpaid family/friend).	• "Too much information." SP 5 • "Same reasons, what can I do about it? I know this sounds jaded, but we have to have social resources if we want to address these social factors and I do not have access to these resources." SP 9	

Abbreviations: SP, Survey Participant; RN, Registered Nurse; Epic, the institution's Electronic Health Record.

are essential during transitions of care, including Case Managers, Clinical Pharmacists, and Social Workers. Respondents felt inpatient clinicians "*kick the can*" without recognizing that PC clinicians have limited resources (eg, revenue, staffing) to handle social circumstances.

Discussion

In seeking to assess the potential usefulness of the RHDS during care transitions, we uncovered both expected and unexpected concerns about the current quality of discharge communication, gaps in the current TCM processes, and ethical concerns related to screening patients for discharge readiness, particularly when a lack of readiness is related to unmet social needs which cannot be addressed by available resources. These results echo previously cited concerns about absent, incomplete, or difficult to read discharge summaries,[5–7] lack of standardized processes, inadequate compensation for care coordination, the need for more training around care transitions,[27,28] and lack of resources available to meet patients' social needs.[29–31]

Half of PC clinicians said they find value in patient discharge readiness assessment information gained from the RHDS. Summarized RHDS information would be welcomed if directed to appropriate members of the PC team, including RN Care Managers, Clinical Pharmacists, and Social Workers. Indeed, other studies have found that TCM that includes Clinical Pharmacists[32] and RNs[33,34] is highly effective in reducing unplanned health care utilization.

That said, PC clinicians had ethical concerns about using the RHDS in the inpatient setting if a lack of readiness and/or unmet needs are not partially or fully addressed before discharge. Though hospitalists may feel pressure to discharge patients as soon as they are medically stable, PC clinicians expressed strong dislike of feeling like hospitalists are "kicking the can" to them without at least *beginning* to address patients' unmet needs.

Still, PC clinicians expressed that if unmet needs information is communicated in a clear and timely manner, the PC team could act by referring patients to resources, or bringing patients in for follow-up sooner, particularly if the RHDS score indicated patients were at risk for readmissions or poor outcomes. Our study suggests that a summary of key RHDS findings should be communicated to outpatient providers, who can continue interventions that are initiated in the hospital, if resources

Table 4. Qualitative Topics and Excerpts from Interviews (n = 12)

Topic 1: Discharge Communication	
Sub-Topic: Views of Current Discharge Communication between Inpatient and Primary Care Settings	
Range of views about automatic discharge notifications and summaries	Positive view *I think it's pretty good from, you know, patients that are discharged from our hospital. Um, you know, we typically get a – a discharge summary that's automatically routed to us. Uh, you know, occasionally there will be some lag in patients being discharged and – and that [the discharge summary] coming. But I think in general, they're – those are helpful. (Interview Participant [IP] 11)* Neutral view *[The discharge summary is the] only communication we get from, uh, anyone on the inpatient team. And then the discharge summary, I'd say, uh, sort of has variable, um, helpfulness in the outpatient setting." (IP 6)* Negative view *I am not satisfied, but I will be fair. It's not because of the lack of effort. Sometimes, it's unsatisfying because the discharge summary is not done until well after I've seen the patient. So, I've got them in the clinic, and I can look at their notes. I can see stuff, but there's not a formal completed discharge summary that an attending has signed off on. Sometimes, it's that they're sending me a million notes and tons of messages. (IP 7)*
Discharge summaries not completed timely	*It is rare that I get a discharge summary [from our hospital] on the same day that the patient left, although it sometimes happens. Um, I would say I've seen patients in clinic and not had a discharge summary, so, not really knowing what things were changed. (IP 2)*
Challenges with interoperability of Electronic Health Records (EHR)	*[When patients are discharged from our hospital] I think the main benefit is that we have access to – readily available access to their EHR, because we use the same EHR so we – can actually do [sic] the notes – Um, and it's really hard to see those labs from other hospitals, um, uh, so that is probably the main benefit. I do think the quality of the discharge summaries, uh, overall is probably better at our hospital. (IP 6)*
Benefits of Care Everywhere	*A lot of times I'll use the* Care Everywhere *feature to try to figure out what went on. And it works pretty well. There's a little bit of a delay in information showing up in* Care Everywhere. *And so if we have an acute follow-up and there's nothing in* Care Everywhere, *I'll sometimes look ahead in my schedule and have a staff contact the institution and say, "Hey, do you have a discharge document?" (IP 10)*
Challenges with incomplete information	*Um, I will – I will get the notification from [another local hospital] that someone was admitted or discharged sometimes. But then, their – their communication that [they] send is useless . . .because they don't include the discharge summary in it. (IP 4)*
Receiving communications about patients that are unknown to them, with no primary care clinician at the time of hospitalization	*Sometimes, it's that they're sending me a million notes and tons of messages. And I'm, "Guys, I've never met this patient. And I'm gonna see them in seven weeks." There's sometimes almost this, like, "Now you take the baton". And there's this weird space in primary care. If somebody's not yet established with me, I don't really want the baton because they might never show up. So, it's this weird – if they're already your patient, it's very different. But a lot of the time, the ones that need the baton passed, they have no primary care physician. They need one, but they might not ever come see you. And so, investing in the plan is hard. (IP 7)*
Sub-topic: Transitional Care Management & Hospital Follow-up Appointment Challenges	
Understanding of current transitional care management process	*I don't know, actually, how many of these they do a week. . . . on our clinic-wide basis, how many patients is that? (IP 9)* *I don't know who they work for. I get these messages sometimes, and I think they're from case managers who have been alerted to certain patients that maybe are getting flagged by the system – as probably potentially having poor outcomes. And so, they will call and actually try and touch base with the patient and ensure that there is a follow-up set up. (IP 1)*
Challenges with hospital follow-up appointments	*I'll go in and see this patient was just discharged and then he's got zero follow-up appointments. So, they've got no follow-up appointments with me. No follow-up with cardiology. . . . I think there's just a missing piece of – in my mind, you shouldn't leave the hospital until you have all of your follow-up appointments scheduled. (IP 12)* *We don't have any frozen appointments for transitions of care. All of us have a certain number of same-day appointments built into our schedules, which we will often use for these appointments – and sometimes that works out appropriately, other times the sort of hiccup that happens is that those same-day appointments are short, 20-minute appointments, really meant for like, address one to two problems, or an acute visit, and then what ends up getting scheduled in is a complicated hospital follow-up. (IP 8)*
Challenges with continuity of care	*A lot of the patients that we have trouble keeping continuity with are the ones that are frequently in the hospital, they get discharged, and then they don't have a follow-up appointment very soon after they're discharged. And there's also not resources in place to make sure they're actually gonna get to the appointment. (IP 1)*
Sub-topic: Improving Discharge Communication	
Brief, clear, and actionable	*I want to know why they went in, what generally happened, and what I have to do. And I wanted it like less than a half-page because I don't have time to spend sifting through the giant document. (IP 2)* *I actually think it's Psych [Psychiatry] who I've seen start doing this, is "Follow-up points for PCP" or something. There's a part of the discharge summary that is like, "They [the patient] need a BMP on July 14th." "They only have meds for 30 days." Actual . . . takeaways that allow me to easily do my job. (IP 7)*

Continued

Table 4. Continued

Topic 1: Discharge Communication	
Summary of medication changes with rationale	*That's my biggest frustration is just the change in medications and the lack of explanation [by inpatient clinicians] to patients as to why these changes were made inpatient and they may have to be changed again outpatient. And then patients feel that they don't have confidence in you or they don't have confidence in their inpatient medicine team, and it's – and it's hard to explain that retroactively. (IP 4)*
Preference for personalized communication	*Rather than just like an auto-routed information, if whoever is discharging that patient sent, like, an individual staff message in Epic to just say, "This is a me-to-you and this isn't just, like, a general routed thing," I feel like that would mean – that would be more meaningful and would, like, you would pay more attention to it and it would be more, like, this is my message to you about this patient. So – that would work. (IP 12)*
Topic 2: Usefulness of the RHDS in the Outpatient Setting	
Value of primary care clinician receiving RHDS at the time of discharge	*I would love to receive that information because, on my end, if I see someone who's, like . . . like, "I am nervous to be home. I don't feel ready. I know that this is something that has to be done, but I'm not confident." Those patients, then, I'm gonna be, like, when I need to see that patient for follow-up not in a week – Or not in two weeks. I wanna see them for follow-up, like, tomorrow. (IP 12)*
Value of implementing the RHDS *before* discharge	*I think really, it's – it's a great tool at generating conversation with the caregiver, with the discharge team. It would be like, okay, how can we set this patient [up] for success? I think that's fantastic. But then, you know, once the patient's discharged, um, you know, I'm happy to follow-up. (IP 3)*
Value of knowing about a "High-Risk" RHDS score	*Yeah. I think that would be helpful. And then, being able to highlight why are they scoring that low – to see in what part of the discharge process is there uncertainty or are people uncomfortable with that we might be able to step in and provide resources to minimize the risk of 30-day readmission. (IP 9)* *If I knew why they were high-risk, like what piece of that is the biggest problem, then it would feel addressable, you know? If I just knew they were high-risk, sometimes I feel paralyzed, right, because I'm like, "Well, what am I supposed to do about this?" . . .This is like where I wish we lived in a world where there were step down units, right? Where they could have an admission, and then a step down, and then a discharge. (IP 8)* *Our Care Managers are making these phone calls. They're calling my patients when they are discharged from the hospital. It would be interesting to know from their point of view would it be helpful for them because so often they call and the patient's like, "Nope. I don't want a visit. I'm fine." But if they looked at this readiness and saw that someone, it may not have been the patient, but was like this patient is not ready for discharge. Could that lead to a flag for them to say, "Well, we know you feel like you're okay, but your doctor really wants to see you. We'd really like to get you a follow-up"? Could it change that conversation? (IP 7)*
Barriers to the using the RHDS as a transitional care tool	In interviews, some primary care clinicians focused on the term *discharge* readiness, saying, *I feel like that's kind of not in my basket of things. Because I guess the way I think about it is, how do I integrate that information, the readiness for hospital discharge, if I'm seeing them post-discharge, day 10? . . . So, I feel like that – that information is information, I think, for the hospital team. More than for us. (IP 8)*
Clinical role best suited to receive the RHDS depends on the problem identified	*So, for example, if they don't understand or aren't tolerating their medication regimen, maybe that should go to the Clinical Pharmacy team. If they are gonna have a huge challenge in getting transportation to us for follow-up, and that's why they're not ready to discharge, that should go to our Care Management team. If they are persistently passively suicidal, that should go to our Behavioral Health team. If they still just don't feel good, that should come to me. Right? And so, I think it depends on what the problem is, and how we solve it. (IP 8)*
Preference for a consolidated summary of responses from the Patient, Caregiver, and RN RHDS	*I don't think that 3 different versions of the same questions are necessary. Need to be more streamlined to allow for ease of use or it will get ignored. (SP 25)*
Sub-topic 4: Lack of Shared Understanding About Roles and Responsibilities Across Settings and Ethical Concerns Related to Lack of Available Resources	
Lack of shared understanding	*I'm a little challenged sometimes when I just get a phone call from someone I don't know on the inpatient team saying, "We're discharging this patient for this thing. You need to see them in two days. Fix that." Right? And – and so I think there is a lack of understanding of our roles and capacities, and their roles and capacities, with a belief that that can happen. (IP 8)*
Ethical concerns about lack of resources	*I feel like I have. . .relatively good knowledge in all of these realms, but I don't always – like, the tools that I have available don't always match my knowledge about what people should have, right? So, there's the perfect world, and then the one I'm operating in. (IP 8)* *I think if you're gonna have a screening tool in the hospital, you have to have the resources to address it and follow through. . .But when there are not adequate resources to then respond, it does raise an ethical question about the value of screening. (IP 10)*

Continued

Table 4. Continued

Topic 2: Usefulness of the RHDS in the Outpatient Setting	
Understaffing in key interdisciplinary roles	*We lost two [case managers] in the last. . .two months, which is really . . . really sad. We have one full-time and one part-time, and that's not even close to enough for the amount of providers . . . That's maybe enough for, like, me and someone else. (IP 2)*
"Kicking the Can" to primary care clinicians	*But unless you actually come up with an action plan in the hospital, you're just kicking the can down the road to me. And I have a 20-minute visit to deal with a patient with seven chronic medical problems who's recently discharged. And, oh, by the way, they have no money for their medication. So, I think if you're gonna have a screening tool in the hospital, you have to have the resources to address it and follow through. Because otherwise, you're just sending it to me. But we're the least funded, least supported branch of medicine. So, you know, the hospital makes money. Marginal on medical beds, much more on procedural beds. Use some of that money to address the needs if you identify them. Otherwise, it's unethical. (IP 10)*

Abbreviations: IP, interview participant; EHR, electronic health records; Epic, the institution's EHR; RN, registered nurse; RHDS, Readiness for Hospital Discharge Scale; BMP, basic metabolic panel.

are available. Strengthening federal and state policies to enhance community-level resources may ultimately help assuage clinicians' ethical concerns about social needs screening in the context of insufficient resources.

In this study, PC clinicians preferred brief, actionable discharge summaries containing the reason for admission, clear rationales for medication changes, and specific implications for outpatient care. Importantly, though inpatient clinicians may be reticent to dictate to another clinician how to practice, PC clinicians in this sample nevertheless expressed the clear desire to know what *specific actions* the discharge team would recommend for them as the patient's PC clinician (eg, draw repeat CBC on June 1). While some PC clinicians noted that direct peer-to-peer calls or messages would personalize communications and better catch their attention, which is consistent with findings from other studies,[9,15] they also expressed understanding this is not always feasible or realistic for either inpatient or outpatient clinicians. Finally, PC clinicians clearly stated that discharge communications should be *timely* – completed as soon as possible after discharge— and *before* the patient is seen in outpatient care.

In this study, participants noted a wide variation in responses to receiving discharge communications. Our sense from the qualitative findings is that this has to do with the fact that discharge summaries are reported to be inconsistent, untimely, long, and do not specify recommended action. This suggests that systems-level improvement in the consistency, timeliness, brevity, and actionable usefulness of discharge summaries may offer a clear pathway forward toward improved transitions. For example, After Visit Summaries meet patients' communication needs by using clear visual displays, appropriate literacy levels, and by specifying self-management recommendations to the patient.[35,36] Our findings suggest that discharge summaries should be designed using similar user-centered methods, including specifying recommended action items for the patient's continuity clinician. This aligns with Unnewehr et al.'s systematic review on optimizing the quality of discharge summaries: while health systems may customize discharge communications as needed, they should adhere to best practices including using concise language, and a consistently clear structure and layout.[28]

While the health system in this study has a TCM process, PC clinicians were unclear on its details; this may be a cautionary tale for health systems currently implementing TCM or struggling with TCM quality. This suggests that efforts to implement or reinforce TCM within a health system should engage both the inpatient discharge team *and* outpatient interdisciplinary team members in all ambulatory settings, particularly within PC. Furthermore, situating TCM processes within PC allows for a fiscal benefit to PC by using billing codes to generate revenue to fund additional interdisciplinary staff dedicated to this critical time for patients.[37]

A TCM core component is a face-to-face visit with a clinician within 7 to 14 days depending on complexity.[2,3] Based on these study data and observations from other unpublished academic health system TCM processes, this health system should consider reserving outpatient hospital follow-up appointments in advance, prioritizing timeliness (ie, within 7 to 14 days), adequate duration (eg, 40 minutes), continuity of care (ie, patients see clinicians they know), regular interprofessional team meetings (ie, to discuss

patients at higher risk of readmission or poor outcomes), and open lines of communication across inpatient-outpatient settings. Member checking for this study also revealed that hospital follow-up appointment scheduling should be streamlined to reduce time-burden for inpatient staff, for example, by having a dedicated phone line to reach outpatient scheduling. This would address PC clinicians' concerns that appointments be made, in consultation with the patient, *before* the patient goes home.

Limitations

This study had limitations. Survey data are subject to social desirability and recall biases. Sampling from 1 academic health system limits generalizability, as does the low response rate. However, we attempted to mitigate this by using a rigorous mixed methods design, which included triangulation of quantitative survey data with qualitative responses in the surveys and interviews, iterating the interview guide to clarify emergent topics, continuing interviews until data saturation was reached, and member checking preliminary data interpretations with both FM and GIM divisions. Respondents were largely young, White, Non-Hispanic, and had been in their role for <10 years. This study only included PC clinicians, so findings may apply differently in specialty outpatient care settings.

Conclusion

This study reiterates perennial – yet still unsolved – challenges with hospital discharge communication and TCM during patients' return to PC settings. Our findings also convey new evidence related to how discharge communication and TCM processes are seen as being interrelated with assessing and responding to patients' lack of readiness for discharge and unmet social needs during care transitions. PC clinicians' views are mixed about whether the RHDS would be a useful tool for communicating patients' readiness for discharge. Some suggested that the RHDS would be helpful in identifying deficiencies in social needs and/or support, prompting actionable interventions by the PC team immediately following hospital discharge, while others stressed that interventions should begin while the patient is still in the hospital and be incorporated with clearer, timely, and directive discharge communication. We offer recommendations for improving discharge communication and TCM processes, which may be applicable in other care settings. Finally, PC clinicians raise concerns about how a lack of sufficient resources – both internal hospital system-based and external community-based – limits their individual agency to address patients' social needs, again reinforcing the importance of buttressing assessment mandates with systemic- and policy-based resources and solutions.

We appreciated the opportunity to present and seek feedback on preliminary findings with the study site's Family Medicine outpatient primary care clinicians, and General Internal Medicine inpatient hospitalists and Advanced Practice Clinicians, and General Internal Medicine outpatient primary care clinicians. Their feedback and perspectives were valuable in shaping our discussion of the study's findings.

To see this article online, please go to: http://jabfm.org/content/37/4/706.full.

References

1. The Joint Commission. Inadequate hand-off communication. Sentinel Event Alert 2017;1–6.
2. *Transitional Care Management Services*. Centers for Medicare and Medicaid Services 2022.
3. Misky GJ, Wald HL, Coleman EA. Post-hospitalization transitions: examining the effects of timing of primary care provider follow-up. J Hosp Med 2010;5:392–7.
4. Kripalani S, Jackson AT, Schnipper JL, Coleman EA. Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. J Hosp Med 2007;2:314–23.
5. Robelia PM, Kashiwagi DT, Jenkins SM, Newman JS, Sorita A. Information transfer and the hospital discharge summary: national primary care provider perspectives of challenges and opportunities. J Am Board Fam Med 2017;30:758–65.
6. Kattel S, Manning DM, Erwin PJ, Wood H, Kashiwagi DT, Murad MH. Information transfer at hospital discharge: a systematic review. J Patient Saf 2020;16:e25–e33.
7. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA 2007;297:831–41.
8. O'Malley AS, Grossman JM, Cohen GR, Kemper NM, Pham HH. Are electronic medical records helpful for care coordination? Experiences of physician practices. J Gen Intern Med 2010;25:177–85.
9. Munchhof A, Gruber R, Lane KA, Bo N, Rattray NA. Beyond discharge summaries: communication preferences in care transitions between hospitalists and primary care providers using electronic medical records. J Gen Intern Med 2020;35:1789–96.

10. Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers B. Addressing social determinants of health: examples of successful evidence-based strategies and current federal efforts. Assistant Secretary for Planning and Evaluation – Office of Health Policy, HP-2022-12. April 2022;1.
11. Bobay KL, Weiss ME, Oswald D, Yakusheva O. Validation of the registered nurse assessment of readiness for hospital discharge scale. Nurs Res 2018;67:305–13.
12. Weiss ME, Costa LL, Yakusheva O, Bobay KL. Validation of patient and nurse short forms of the Readiness for Hospital Discharge Scale and their relationship to return to the hospital. Health Serv Res 2014;49:304–17.
13. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap): a metadata-driven methodology and workflow process for providing translational research informatics support. J Biomed Inform 2009;42:377–81.
14. Harris PA, Taylor R, Minor BL, REDCap Consortium, et al. The REDCap consortium: building an international community of software platform partners. J Biomed Inform. 2019;95:103208.
15. Sheu L, Fung K, Mourad M, Ranji S, Wu E. We need to talk: primary care provider communication at discharge in the era of a shared electronic medical record. J Hosp Med 2015;10:307–10.
16. Riffin C, Wolff JL, Butterworth J, Adelman RD, Pillemer KA. Challenges and approaches to involving family caregivers in primary care. Patient Educ Couns 2021;104:1644–51.
17. Boch S, Keedy H, Chavez L, Dolce M, Chisolm D. An integrative review of social determinants of health screenings used in primary care settings. J Health Care Poor Underserved 2020;31:603–22.
18. Riffin C, Wolff JL, Pillemer KA. Assessing and addressing family caregivers' needs and risks in primary care. J Am Geriatr Soc 2021;69:432–40.
19. Tong ST, Liaw WR, Kashiri PL, et al. Clinician experiences with screening for social needs in primary care. J Am Board Fam Med 2018;31:351–63.
20. StataCorp. Stata Statistical Software: Release 17. StataCorp LLC; 2021.
21. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3:77–101.
22. Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs 2008;62:107–15.
23. Lincoln YS, Guba E. *Naturalistic Inquiry*. 1st ed. SAGE Publications; 1985.
24. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant 2018;52:1893–907.
25. Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. Qual Health Res 2015;25:1212–22.
26. Epic. Organizations on the Care Everywhere Network. Accessed March 3, 2023. Available at: https://www.epic.com/careeverywhere/.
27. Davis MM, Devoe M, Kansagara D, Nicolaidis C, Englander H. "Did I do as best as the system would let me?" Healthcare professional views on hospital to home care transitions. J Gen Intern Med 2012;27:1649–56.
28. Unnewehr M, Schaaf B, Marev R, Fitch J, Friederichs H. Optimizing the quality of hospital discharge summaries: a systematic review and practical tools. Postgrad Med 2015;127:630–9.
29. Why more evidence is needed on the effectiveness of screening for social needs among high-use patients in acute care settings. Health Affairs Blog May 23, 2019. Accessed August 28, 2023. Available at: http://10.1377/hblog20190520.243444.
30. Garg A, Byhoff E, Wexler MG. Implementation considerations for social determinants of health screening and referral interventions. JAMA Netw Open 2020;3:e200693.
31. Garg A, Boynton-Jarrett R, Dworkin PH. Avoiding the unintended consequences of screening for social determinants of health. JAMA 2016;316:813–4.
32. Villeneuve Y, Courtemanche F, Firoozi F, et al. Impact of pharmacist interventions during transition of care in older adults to reduce the use of healthcare services: a scoping review. Res Social Adm Pharm 2021;17:1361–72.
33. Hirschman K, Shaid E, McCauley K, Pauly M, Naylor M. Continuity of care: the transitional care model. Online J Issues Nurs 2015;20.
34. Straßner C, Hoffmann M, Forstner J, Roth C, Szecsenyi J, Wensing M. Interventions to improve hospital admission and discharge management: an umbrella review of systematic reviews. Qual Manag Health Care 2020;29:67–75.
35. Clarke MA, Moore JL, Steege LM, et al. Toward a patient-centered ambulatory after-visit summary: identifying primary care patients' information needs. Inform Health Soc Care 2018;43:248–63.
36. Federman AD, Jandorf L, DeLuca J, et al. Evaluation of a patient-centered after visit summary in primary care. Patient Educ Couns 2018;101:1483–9.
37. Agarwal SD, Barnett ML, Souza J, Landon BE. Medicare's care management codes might not support primary care as expected. Health Aff (Millwood) 2020;39:828–36.

Appendix 1. Additional Details About the Readiness for Hospital Discharge Scale

Additional details about the Readiness for Hospital Discharge Scale (RHDS) can be found on the Marquette University webpage.[25] Different versions of the RHDS – for patients (e.g., adults, children, and post-partum mothers), caregivers, registered nurses (RN), and physicians – vary primarily in the phrasing of the questions with the central focus remaining always on the patient. For example, the patient version of question 1 reads "How physically ready are *you* to go home?" whereas the RN version reads "How physically ready is *your patient* to go home?" Scoring is done by adding item scores and dividing by the number of items, which calculates a mean score on a 0 to 10 scale. Subscale scoring is also possible. The Marquette University webpage includes a database of approved translations of the RHDS in various languages and a bibliography of references related to instrument development. Note that the study authors had permission to use the scale, but are not the original creators of the scale.

Appendix 2. Ninety-Four-Item Electronic REDCap Survey

Item #	Field Name	Field Label *Field Note*	Attributes & Responses
1	[record_id]	Record ID	text
2	[consent_cover]	Consent Cover Letter…	descriptive
3	[role]	Section Header: *The first part of the survey focuses on general questions about your professional role, practice and primary care clinic setting.* What is your professional role?	radio, Required 1 Attending Physician 2 Fellow 3 Resident Physician 4 Physician Assistant 5 Nurse Practitioner 6 Other 8 Do not wish to respond
4	[residency_year] Show the field ONLY if: [role] = 3	What year of residency training are you currently in?	dropdown, Required 1 1 2 2 3 3 4 4 8 Do not wish to respond
5	[other_role] Show the field ONLY if: [role] = 6	You selected 'Other' for your professional role? Please describe your role.	text, Required
6	[role_time]	How long have you been practicing in your current role?	radio, Required 1 Less than 1 year 2 1 - 5 years 3 6 - 10 years 4 More than 10 years 8 Do not wish to respond
7	[monthly_time_in_clinic]	How many hours do you spend in clinic seeing patients each month (on average)?	radio, Required 1 4 hours or fewer 2 5 - 8 hours 3 9 - 12 hours 4 13 - 16 hours 5 17 to 21 hours 6 22 hours or more 8 Do not wish to respond
8	[panel_size]	How many patients do you have on your current patient panel? (Please select the nearest approximate panel size.)	radio, Required 1 None 2 1 - 99 3 100 - 199 4 200 - 299 5 300 or more 8 Do not wish to respond

9	[why_no_patients] Show the field ONLY if: [panel_size] = 1	You said that you have no patients on your panel currently. Could you briefly explain why?	text, Required
10	[accepting_new_patients]	Are you currently accepting new patients on your panel?	radio, Required 1 Yes 2 No 8 Do not wish to respond
11	[interprofessional]	Thinking of the clinic where you see primary care patients most often, which of the following inter-professional team members are integrated into your clinic, and available to you to collaborate with or support patient care? (select all that apply)	checkbox 1 Medical Assistant/Licensed Practical Nurse 2 Registered Nurse 3 Registered Nurse Care Manager 4 Social Worker 5 Integrated Behavioral Health/Psychologist 6 Psychiatrist 7 Clinical Pharmacist 8 Speech Therapist 9 Occupational Therapist 10 Physical Therapist 11 Dietitian 12 Other
12	[other_interprof] Show the field ONLY if: [interprofessional(12)] = 1	You answered 'Other' to the question about interprofessional team members available in your clinic. Please explain what other roles are integrated into your clinic.	notes, Required
13	[hospital_discharges]	How many of your primary care patients have been discharged from the University of Utah Hospital in the last year?	radio 1 None 2 1 - 5 3 6 - 10 4 11 - 20 5 21 or more
14	[admission_auto_notify]	Section Header: *This section focuses on your view of communication about patient ADMISSIONS to the University of Utah hospital.* How often are you getting automatic notifications of your patients' ADMISSION through Epic? _____% of the time.	radio 1 0-25% 2 25-50% 3 50-75% 4 75-100%
15	[admission_auto_ownpatient]	When you are notified of a patient ADMISSION through Epic, how often do you recognize the patient as a patient you know well and consider to be as "your" patient? _____% of the time.	radio 1 0-25% 2 25-50% 3 50-75% 4 75-100%

16	[admission_auto_helpful]	How helpful do you find automatic ADMISSION notifications in Epic?	radio 1 Very Unhelpful 2 Unhelpful 3 Neutral 4 Helpful 5 Very Helpful
17	[admission_what_doyoudo]	Please briefly describe: what do you do when you receive an ADMISSION notification in Epic? If you do not wish to respond, type "n/a".	notes, Required
18	[discharge_auto_notify]	Section Header: *This section focuses on your view of communication about patient DISCHARGES from the University of Utah hospital back to home and primary care.* How often are you getting automatic notifications of your patients' DISCHARGE through Epic? _____% of the time.	radio 1 0-25% 2 25-50% 3 50-75% 4 75-100%
19	[discharge_ownpatient]	When you are notified of a patient DISCHARGE through Epic, how often do you recognize the patient as a patient you know well and consider to be a patient on your panel? _____% of the time.	radio 1 0-25% 2 25-50% 3 50-75% 4 75-100%
20	[discharge_receive_summary]	When you receive an automatic notification at DISCHARGE, a discharge summary should also be automatically attached. How often is this happening? _____% of the time.	radio 1 0-25% 2 25-50% 3 50-75% 4 75-100%
21	[discharge_direct_contact]	How often do you receive additional direct contact (email, in-basket note, phone call, page, etc) from the Inpatient Team at DISCHARGE? _____% of the time.	radio 1 0-25% 2 25-50% 3 50-75% 4 75-100%
22	[discharge_direct_who]	When you receive direct contact about a patient who has been discharged, who do you receive contact from most often?	radio 1 Inpatient resident physician 2 Inpatient attending physician 3 Inpatient Advanced Practice Clinician (APC) 4 Inpatient case manager 5 Inpatient social worker 6 Other 7 I have never received direct communication about a patient discharge from anyone
23	[discharge_direct_who_other]	You noted that you have received direct contact from other team members. Please describe who you	notes, Required

	Show the field ONLY if: [discharge_direct_who] = 6	have received direct contact from. If you do not wish to respond, type "n/a".	
24	[discharge_direct_common]	When you receive direct contact about a patient who has been discharged, what is the most common communication method?	radio 1 Email 2 In-basket message in Epic 3 Phone call 4 Text page 5 In-person (face to face) 6 Other 7 I have never received direct communication about a patient discharge through any method
25	[discharge_direct_other] Show the field ONLY if: [discharge_direct_common] = 6	You noted that you have received direct contact through other methods. Please describe how this has been done. If you do not wish to respond, type "n/a".	notes, Required
26	[discharge_comm_satisfied]	How satisfied are you with communication between in-patient providers and you as a primary care provider (excluding Epic automatic notifications) at the time of DISCHARGE?	radio 1 Very Dissatisfied 2 Dissatisfied 3 Neutral 4 Satisfied 5 Very Satisfied
27	[discharge_auto_helpful]	How helpful do you find automatic DISCHARGE notifications in Epic?	radio 1 Very Unhelpful 2 Unhelpful 3 Neutral 4 Helpful 5 Very Helpful
28	[discharge_what_doyoudo]	Please briefly describe: What do you do when you receive an automatic discharge notification in Epic? If you do not wish to respond, type "n/a".	notes, Required
29	[social_needs_screen]	Section Header: *This section focuses on your perspective about screening patients for SOCIAL NEEDS. "Social needs" includes things such as transportation, food, housing, or household goods. We define social needs and social support differently. "Social support" is when patients have someone to help them with common tasks such as giving them a ride to an appointment, running errands, cooking, bathing, dressing changes, or medication management. We will ask about social support in a later section. Again, SOCIAL NEEDS includes things such as transportation, food, housing, or household goods.*	yesno 1 Yes 0 No

		Do you or others in your practice routinely screen for SOCIAL NEEDS (needs for things such as transportation, food, housing, or household goods)?	
30	[screen_how] Show the field ONLY if: [social_needs_screen] = 1	How is SOCIAL NEEDS screening completed most of the time?	radio 1 Patient self-report 2 Completed by clinic staff 4 Other 88 I don't know
31	[role_socialneed_screen] Show the field ONLY if: [screen_how]=2	In your clinic, which professional role is primarily responsible for completing the SOCIAL NEEDS screening?	radio 1 Physician/Advanced Practice Clinician 2 Medical Assistant/Licensed Professional Nurse (MA/LPN) 3 Registered Nurse (RN) 4 Case manager 5 Social worker 6 Other
32	[social_needs_screen_other] Show the field ONLY if: [role_socialneed_screen] = 6	You answered "other" to the previous question. Which professional role is primarily responsible for completing SOCIAL NEEDS screening in your clinic? If you do not wish to respond, type "n/a".	text, Required
33	[social_needs_patient] Show the field ONLY if: [social_needs_screen] = 1	How is it decided which patients are screened for SOCIAL NEEDS? If you do not wish to respond, type "n/a".	notes, Required
34	[screen_frequency] Show the field ONLY if: [social_needs_screen] = 1	How frequently are patients screened for SOCIAL NEEDS?	radio 1 Every visit 2 Once per month 3 Once per year 4 During their very first visit to the clinic 5 Other 88 I don't know
35	[social_needs_freq_other] Show the field ONLY if: [screen_frequency] = 5	You answered "Other" the previous question. How frequently are patients screened for SOCIAL NEEDS? If you do not wish to respond, type "n/a".	text, Required
36	[social_needs_how_other] Show the field ONLY if: [screen_how] = 4	You answered "Other" the previous question. How is SOCIAL NEEDS screening completed? If you do not wish to respond, type "n/a".	notes, Required

37	[social_screen_where_emr] Show the field ONLY if: [social_needs_screen] = 1	How/where is information about SOCIAL NEEDS documented in Epic most of the time?	radio 1 In a flowsheet 2 In an encounter note 3 Under the "Social History" tab 4 SDOH Wheel 5 Other 88 I don't know
38	[social_needs_where_other] Show the field ONLY if: [social_screen_where_emr] = 5	You answered "Other" the previous question. How/where is information about SOCIAL NEEDS documented in Epic? If you do not wish to respond, type "n/a".	notes, Required
39	[screen_which_needs] Show the field ONLY if: [social_needs_screen] = 1	Which SOCIAL NEEDS are screened for? (select all that apply)	checkbox 1 Food security 2 Housing instability 3 Utility needs 4 Transportation needs 5 Interpersonal violence 6 Other 88 I don't know
40	[needs_other] Show the field ONLY if: [screen_which_needs(6)] = 1	You answered "Other" to the previous question. Please explain: which other SOCIAL NEEDS do you screen for? If you do not wish to respond, type "n/a".	notes, Required
41	[need_action] Show the field ONLY if: [social_needs_screen] = 1	If a screening reveals a SOCIAL NEED, what actions do you take most of the time?	radio 1 Refer to clinic Social Worker 2 Refer to Care Manager 3 Refer to Connect2Health student 4 Refer to outside agency 5 Other
42	[needs_action_other] Show the field ONLY if: [need_action] = 5	You answered "Other" the previous question. Please explain: if a screening reveals a SOCIAL NEEDS, what actions do you take? If you do not wish to respond, type "n/a".	notes, Required
43	[screen_helpful] Show the field ONLY if: [social_needs_screen] = '1'	How helpful do you think the screening is for identifying patients with SOCIAL NEEDS?	radio 1 Very Unhelpful 2 Unhelpful 3 Neutral 4 Helpful 5 Very Helpful
44	[ifscreen_would_helpful] Show the field ONLY if:	How helpful do you think the screening would be for identifying patients with SOCIAL NEEDS?	radio 1 Very Unhelpful 2 Unhelpful

	[social_needs_screen] = '0'		3 Neutral 4 Helpful 5 Very Helpful
45	[social_support_screen]	Section Header: *This section focuses on your perspective about screening patients for SOCIAL SUPPORT. "Social support" is when patients have someone to help them with common tasks such as giving them a ride to an appointment, running errands, cooking, bathing, dressing changes, or medication management.* Do you or others in your practice routinely screen for SOCIAL SUPPORT (whether they have someone to help them with common tasks such as giving them a ride to an appointment, running errands, cooking, bathing, dressing changes, or medication management)?	yesno 1 Yes 0 No
46	[screen_support_how] Show the field ONLY if: [social_support_screen] = 1	How is screening for SOCIAL SUPPORTS completed most of the time?	radio 1 Patient self-report 2 Completed by clinic staff 4 Other 88 I don't know
47	[role_socialsupport_screen] Show the field ONLY if: [screen_support_how] = 2	In your clinic, which professional role is primarily responsible for completing the SOCIAL SUPPORT screening?	radio 1 Physician/Advanced Practice Clinician (APC) 2 Medical Assistant/Licensed Professional Nurse (MA/LPN) 3 Registered Nurse (RN) 4 Case manager 5 Social worker 6 Other
48	[supportscreen_role_other] Show the field ONLY if: [role_socialsupport_screen] = 6	You answered "other" to the previous question. Which professional role is responsible for completing SOCIAL SUPPORT screening in your clinic?	text
49	[social_support_patient] Show the field ONLY if: [social_support_screen] = 1	How is it decided which patients are screened for SOCIAL SUPPORT?	notes
50	[screen_support_frequency] Show the field ONLY if: [social_support_screen] = 1	How frequently are patients screened for SOCIAL SUPPORT?	radio 1 Every visit 2 Once per month 3 Once per year 4 During their very first visit to the clinic 5 Other 88 I don't know

51	[social_supportfreq_other] Show the field ONLY if: [screen_support_frequency] = 5	You answered "other" to the previous question. How frequently are patients screened for SOCIAL SUPPORT? If you do not wish to respond, type "n/a".	text, Required
52	[supportscreen_how_other] Show the field ONLY if: [screen_support_how] = 4	You answered "other" to the previous question. How is screening for SOCIAL SUPPORT completed? If you do not wish to respond, type "n/a".	text, Required
53	[social_support_which] Show the field ONLY if: [social_support_screen] = 1	Which SOCIAL SUPPORTS are screened for? (select all that apply) Someone to help with ...	checkbox 1 Transportation 2 Running errands 3 Cooking / meal preparation 4 Bathing 5 Dressing changes 6 Medication management 7 Other 88 I don't know
54	[social_supportwhich_other] Show the field ONLY if: [social_support_which(7)] = 1	You answered "other" to the previous question. Which SOCIAL SUPPORT are screened for? If you do not wish to respond, type "n/a".	text, Required
55	[support_action] Show the field ONLY if: [social_support_screen] = 1	If a screening reveals a lack of SOCIAL SUPPORT, what actions do you take most of the time?	radio 1 Refer to clinic Social Worker 2 Refer to Care Manager 3 Refer to Connect2Health student 4 Refer to outside agency 5 Other
56	[support_action_other] Show the field ONLY if: [support_action] = '5'	You answered "Other" the previous question. Please explain: if a screening reveals a lacking SOCIAL SUPPORT, what actions do you take? If you do not wish to respond, type "n/a".	notes, Required
57	[screen_support_helpful] Show the field ONLY if: [social_support_screen] = 1	How helpful do you think the screening is for identifying patients without SOCIAL SUPPORT?	radio 1 Very Unhelpful 2 Unhelpful 3 Neutral 4 Helpful 5 Very Helpful
58	[screen_sup_would_helpful]	How helpful do you think the screening would be for identifying patients without SOCIAL SUPPORT?	radio 1 Very Unhelpful

	Show the field ONLY if: [social_support_screen] = '0'		2 Unhelpful 3 Neutral 4 Helpful 5 Very Helpful
59	[improves_interactions]	Section Header: Do you think your current systems' methods of addressing social needs and resources helps improve interactions with the patient?	radio, Required 1 Yes 0 No 8 Do not wish to respond
60	[improves_knowledge]	Do you think your current systems' methods of addressing social needs and resources helps improve knowledge of the patient?	radio, Required 1 Yes 0 No 8 Do not wish to respond
61	[improves_care_delivery]	Do you think information about social needs and social support helps improve care delivery?	radio, Required 1 Yes 0 No 8 Do not wish to respond
62	[rn_rhds]	Section Header: *We have integrated a number of assessments in Epic to help the inpatient discharge team assess social needs, social support and discharge readiness. We are interested in understanding whether and how PCPs would find these assessments helpful. In the next section, you will be shown screenshots of these assessments and asked for your feedback.* Inpatient Registered Nurses are asked to complete this "Readiness for Hospital Discharge Scale" (RHDS) about each patient at the time of discharge. The validated 8-item survey (as shown) uses a 0 to 10 point rating scale for each item; higher scores indicate greater patient readiness for discharge. A score of less than 7 indicates low readiness and has been associated with poorer health outcomes and greater risk of readmission. Weiss, M.E. & Piacentine, L.B. (2006). Psychometric properties of the Readiness for Hospital Discharge Scale. Journal of Nursing Measurement, 14(3), 163-180. Additional information about the RHDS can be found here: https://www.marquette.edu/nursing/readiness-hospital-discharge-scale.php	descriptive
63	[receive_rn_rhds]	Would you like to receive this information about the patient's readiness for discharge from the inpatient Registered Nurse's perspective at the time of patient's discharge?	yesno 1 Yes 0 No

64	[rn_whynot] Show the field ONLY if: [receive_rn_rhds] = '0'	You replied that you do not want to receive information about the patient's readiness for discharge from the inpatient Registered Nurse's perspective at the time of patient's discharge inpatient. Please share your thoughts on why you do not want to receive this information.	notes
65	[rn_rhds_how] Show the field ONLY if: [receive_rn_rhds] = 1	How would you prefer to receive the inpatient Registered Nurse's answers to the RHDS?	radio 1, Include in discharge summary 2, By Epic in-basket message 3, By email 4, Other
66	[rn_rhds_how_other] Show the field ONLY if: [rn_rhds_how] = 4	You answered "Other" the previous question. How would you prefer to receive the inpatient registered nurse's answers to the RHDS? If you do not wish to respond, type "n/a".	text, Required
67	[rn_rhds_when] Show the field ONLY if: [receive_rn_rhds] = 1	When would you prefer to receive information from the inpatient Registered Nurse about the patient's readiness for discharge (RHDS)?	radio 1, Prior to discharge 2, The day of discharge 3, Before the patient's next appointment with me 4, Other
68	[rn_rhds_when_other] Show the field ONLY if: [rn_rhds_when] = 4	You answered "Other" the previous question. When would you prefer to receive the inpatient registered nurse's answers to the RHDS? If you do not wish to respond, type "n/a/".	text, Required
69	[rn_rhds_actions] Show the field ONLY if: [receive_rn_rhds] = 1	What actions would you take if you found out that the inpatient Registered Nurse had concerns about the patient at the time of discharge? If you do not wish to respond, type "n/a".	notes, Required
70	[pt_rhds]	Section Header: We have also been collecting the same RHDS information about discharge readiness from the PATIENTS themselves. An image of the 8-item RHDS for patients is shown.	descriptive, Required
71	[receive_pt_rhds]	Would you like to receive this information about the patient's readiness for discharge from the PATIENT's perspective at the time of patient's discharge?	yesno 1, Yes 0, No
72	[pt_whynot] Show the field ONLY if: [receive_pt_rhds] = '0'	You replied that you do not want to receive information about the patient's readiness for discharge from the inpatient Registered Nurse's perspective at the time of patient's discharge inpatient. Please share your thoughts on why you do not want to receive this information.	notes

73	[pt_rhds_how] Show the field ONLY if: [receive_pt_rhds] = 1	How would you prefer to receive the PATIENTS's answers to the RHDS?	radio 1 Include in discharge summary 2 By Epic in-basket message 3 By email 4 Other
74	[pt_rhds_how_other] Show the field ONLY if: [pt_rhds_how] = 4	You answered "Other" the previous question. How would you prefer to receive the PATIENT's answers to the RHDS? If you do not wish to answer, type "n/a".	text, Required
75	[pt_rhds_when] Show the field ONLY if: [receive_pt_rhds] = 1	When would you prefer to receive information from the PATIENT's readiness for discharge?	radio 1 Prior to discharge 2 The day of discharge 3 Before the patient's next appointment with me 4 Other
76	[pt_rhds_when_other] Show the field ONLY if: [pt_rhds_when] = 4	You answered "Other" the previous question. When would you prefer to receive the PATIENT's answers to the RHDS? If you do not wish to answer, type "n/a".	text, Required
77	[pt_rhds_actions] Show the field ONLY if: [receive_pt_rhds] = 1	What actions would you take if you found out that the PATIENT had concerns about themselves at the time of discharge? If you do not wish to answer, type "n/a".	notes, Required
78	[receive_cg_rhds]	Section Header: *In addition to asking the inpatient Registered Nurse and the patient to complete the RHDS, we are also asking CAREGIVERS to complete the RHDS. Caregivers could be a family member, friend or another informal or unpaid social support person who is identified during the patient's hospital stay. Caregivers answer the same 8-item RHDS. CAREGIVERS are asked about their perception of the patient's readiness for hospital discharge.* Would you like to receive this information about the patient's readiness for discharge from the CAREGIVERS's perspective about the patient's readiness for discharge?	yesno 1 Yes 0 No
79	[cg_whynot] Show the field ONLY if: [receive_cg_rhds] = '0'	You replied that you do not want to receive information about the patient's readiness for discharge from the inpatient Registered Nurse's perspective at the time of patient's discharge inpatient. Please share your thoughts on why you do not want to receive this information.	notes
80	[cg_rhds_how] Show the field ONLY if:	How would you prefer to receive the CAREGIVERS's answers to the RHDS?	radio 1 Include in discharge summary

	[receive_cg_rhds] = 1		2 By Epic in-basket message 3 By email 4 Other
81	[cg_rhds_how_other] Show the field ONLY if: [cg_rhds_how] = 4	You answered "Other" to the previous question. How would you prefer to receive the CAREGIVERS's answers to the RHDS? If you do not wish to answer, type "n/a".	text, Required
82	[cg_rhds_when] Show the field ONLY if: [receive_cg_rhds] = 1	When would you prefer to receive information from the CAREGIVER's readiness for discharge?	radio 1 Prior to discharge 2 The day of discharge 3 Before the patient's next appointment with me 4 Other
83	[cg_rhds_when_other] Show the field ONLY if: [cg_rhds_when] = 4	You answered "Other" to the previous question. When would you prefer to receive the CAREGIVERS's answers to the RHDS? If you do not wish to answer, type "n/a".	text, Required
84	[cg_rhds_actions] Show the field ONLY if: [receive_cg_rhds] = 1	What actions would you take if you found out that the CAREGIVER had concerns about the patient at the time of discharge? If you do not wish to answer, type "n/a".	notes, Required
85	[phys_ready]	Section Header: *We are thinking about how we could revise the CAREGIVER RHDS screener to make it more useful to Primary Care Providers. In the current RHDS, we are asking the caregiver about their perception of the patient's readiness for discharge. Please rank these items in order of importance to you. FIRST, select the item that you think is MOST important and mark that with a 1. THEN, select the item that you think is LEAST important and mark that with an 8. LAST, rank the importance of the remaining items beginning with the SECOND MOST important item (mark with 2), and so on. 1 = most important, 8 = least important* How physically ready is your patient to leave the hospital for the next place they are staying (for example, home, skilled nursing facility, long term acute care facility)?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8
86	[energy]	How would you describe your patient's energy today?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6

			7 7 8 8
87	[problems_to_watch]	How much does your patient know about problems to watch for?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8
88	[restrictions]	How much does your patient know about restrictions (what he/she is allowed and not allowed to do)?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8
89	[handle_demands]	How well will your patient be able to handle the demands of life at the next place they are staying?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8
90	[perform_personal_care]	How well will your patient be able to perform his/her personal care (for example, hygiene, bathing, toileting, eating) at the next place they are staying?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8
91	[help_personal_care]	How much help will your patient have available if needed with his/her personal care at the next place they are staying?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8

92	[help_medical_care]	How much help will your patient have available if needed with his/her medical care needs (treatments, medications) at the next place they are staying?	radio (Matrix - ranking) 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8
93	[cg_missing]	Is there anything missing from the CAREGIVER RHDS screener that you think we should ask?	notes
94	[cg_leaveout]	Is there anything that could be left out of the CAREGIVER RHDS screener?	notes

Notes.

Items 3, 13-18, 20, 21 and 26 were adapted from Sheu L, Fung K, Mourad M, Ranji S, Wu E. We need to talk: Primary care provider communication at discharge in the era of a shared electronic medical record. *J Hosp Med*. 2015;10(5):307-310. doi:10.1002/jhm.2336

Items 29-42 inquiring about social needs and the corresponding questions (45-56) related to social support were adapted from Boch S, Keedy H, Chavez L, Dolce M, Chisolm D. An integrative review of social determinants of health screenings used in primary care settings. *J Health Care Poor Underserved*. 2020;31(2):603-622. doi:10.1353/hpu.2020.0048

Results from items 85-94 were used as preliminary data for a different study.

Appendix 3. Interview Guide Domains, Sub-domains with Definitions and Codes: Discharge Communication, Social Needs Screening, and Readiness for Hospital Discharge Scale

Domain	Sub-domain with Definition	Codes
Organizational & Practice Characteristics	• Department/division	• Division – anonymized
	• Clinic	• Clinic – anonymized
	• Time spent in clinic seeing patients	• Hours per week
	• Precepting residents	• Precepting residents
	• Size of outpatient panel	• Panel size
	• Ever work in-patient	• Ever work in-patient
	• Familiarity with in-patient clinicians	• Familiarity with in-patient–anonymized as needed
Individual Characteristics	• Interviewee role	• Role
	• Education or training around social needs and social support (formal or informal)	• Education/training
	• Feeling prepared to address social needs in practice	• Feeling prepared
Discharge Communication from Hospital to Primary Care Clinicians	• Satisfaction with discharge communication from hospital – general feelings	• Discharge coms satisfaction • Passing the baton
	• Timing of discharge communication – when they are received (or completed/signed) from inpatient clinicians	• Timing discharge coms
	• Suggestions for improvement in discharge communications - broad	• Improving discharge coms
	• Setting up follow up appointments before discharge – outpatient primary care clinicians think the inpatient team should be scheduling follow up appt before the patient leaves the hospital	• Follow up appt before discharge
	• Primary care clinician being able to see patient for follow up sooner/fitting in patients who need to be seen sooner – from the outpatient clinician's perspective	• Fitting in pts who need to be seen sooner
	• Dedicated transitional care management appointment slots – appointments on a clinician's schedule that are held for patients who need "hospital follow up appointment"	• Dedicated transitional care management appts
	• Variations in discharge communications by area hospitals or by specialty	• Variations in discharge coms
	• Direct in-patient/outpatient communication at the time of discharge	• Direct in-patient/outpatient communication

	• Suggesting that the inpatient team might benefit from receiving information from the primary care clinician who knows the patient	• Bidirectional flow of information
	• Lack of resources – lack of resource, or not enough funding for resources, could be person or organization • Having vs. not having a primary care clinician at the time of discharge	• Lack of resources
Social Needs Screening	• General thoughts about social risk screening in primary care	• Social risk screen in PC
	• Who benefits from screening (e.g., patient population)?	• Who benefits
	• Percentage of patients who benefit from screening?	• Percentage of patients
	• Which specific social needs are identified? (Catch-all, whatever is identified, e.g., food, housing, money, transportation, medications)	• Specific social needs • Easier needs to address • Harder needs to address
	• Ethics of screening	• Ethics of screening
Views of Readiness for Hospital Discharge Scale (RHDS)	• General thoughts about receiving RHDS details in discharge communications	• General view of RHDS
	• "We don't really have the capacity to…" – staffing, (resources?), or individual time/energy to deal with this	• No capacity
	• Social needs are not a priority, medical issues come first	• Not priority
	• Best outpatient role to receive RHDS information	• Which role RHDS
	• Usefulness of RHDS for primary care clinicians	• Usefulness of RHDS for primary care clinicians
	• What RHDS information might trigger an intervention by primary care team (clinician, care manager, social worker, etc.)	• What triggers intervention

	• Value of varied RHDS perspectives: in-patient registered nurse vs. patient vs. patient identified informal caregiver, or which one they think is most important	• Value of 3 RHDS perspectives
		  ○ Caregiver
		  ○ Nurse
		  ○ Patient
		  ○ Combination

	• Usefulness of knowing score cut off as predictor of unplanned service use	• Usefulness of high-risk score

Additional Inductive Codes	• Interdisciplinary roles available in clinic or health system – as in, this is the person who deals with social needs, may vary depending on what the social need is (i.e., medication need handled by Clinical Pharmacist, transportation handled by Social Worker).	• Interdisciplinary roles
	• Understaffing in clinic	• Understaffing
	• Patient doesn't always come to primary care clinician for follow up – even if scheduled, patient doesn't follow up, or they don't even make an appt to follow up.	• Pt no follow up
	• Primary care clinician saying that they don't get paid for care outside of visit (if they make phone calls, or have to read medical records, or if a caregiver has a question outside of a visit)	• Reimbursement
	• Clinician perception of available resources (e.g. Medicaid transportation, etc.) – lack of knowledge about resources, complications with resources, variations in resources depending on insurance coverage	• Provider perception/knowledge of resources
	• Lack of understanding across settings – meaning that the inpatient team does not have a realistic view of what can be done by out-patient clinicians; or primary care clinicians, saying they don't know what it's like on the inpatient side. Resulting in passing the problem down the line, or "passing the baton".	• Lack of understanding across settings
	• Issues with Electronic Health Record (EHR) – general frustration with lack of functionality of EHR, or "in-basket is overflowing with too many messages"	• Issues with EHR