ITEM 1

A 61-year-old woman who experienced a seizure is brought to the emergency department for evaluation. She is initiated on phenytoin, and for the next 7 days in the hospital, she remains seizure free. The inpatient neurology team now plans to discharge the patient home on phenytoin 300 mg/day. The hospital uses the 8Ps tool before her discharge. The 8Ps tool evaluates problem medications, psychological issues, principal diagnosis, polypharmacy, low health literacy, patient support, prior hospitalizations, and palliative care. The patient's discharge medications include phenytoin, insulin glargine, glipizide, atorvastatin, lisinopril/hydrochlorothiazide, aspirin, and clopidogrel. The 8Ps tool notes that this hospitalization is the patient's first since her knee replacement 18 months ago. After being discharged home, where she lives with her husband, she has a scheduled follow-up in the outpatient neurology clinic within 1 week. Which one of the following areas covered by the 8Ps assessment is most likely to show this patient to be at risk of a postdischarge adverse event?

A. Problem drugs.
B. Principal diagnosis.
C. Patient support.
D. Previous hospitalizations.

ITEM 1 (Continuity of Care/Medication Reconciliation)

Answer A: Problem drugs.

Many validated tools to evaluate general and health literacy have been published in the literature. Because nonadherence and adverse events are higher among patients with low health literacy, a simple screening tool is useful for clinicians in assessing this risk factor. The patient's drug list includes insulin, aspirin, and clopidogrel; in addition to warfarin and digoxin, these three drugs increase the likelihood of adverse events after discharge (Answer A is correct). Cancer, stroke, diabetes/glycemic complications, chronic obstructive pulmonary disease, and heart failure have been identified as principal diagnoses likely to result in rehospitalization (Answer B is incorrect). Factors less likely to result in an adverse event are a support system for a patient whose spouse is at home and a previous hospitalization that was more than 6 months ago (Answer C and Answer D are incorrect).

1. Society of Hospital Medicine. Quality Initiatives: BOOSTing the Care Transition [homepage on the Internet].
2. Graumlich JF, Novotny NL, Nace GS, et al. Patient and physician perceptions after software-assisted hospital discharge: cluster randomized trial. J Hosp Med 2009;4:356-63.