Introduction to the Getting Ready for Discharge Toolkit

Why Discharge Planning Matters

Reducing hospital readmissions is a national priority for payers, providers, and policymakers in the pursuit of improved health care at lower costs.[1]

In recent years, programs, policies, and initiatives that support health system stakeholders' focus on readmissions and transitions of care include:

- Quality measures focused on 30-day All-Cause Readmissions for providers, Accountable Care Organizations (ACOs), health plans, and hospitals[2-9]
- Merit-based Incentive Payment System (MIPS) physician improvement activities for transitions of care[10]
- The Hospital Readmission Reduction Program (HRRP) established as part of the Affordable Care Act (ACA) in 2012[11]

Through these quality programs, hospitals and health systems are incentivized to improve communication and care coordination efforts to better engage patients and caregivers on post-discharge planning.[2-11]

When an individual experiences a readmission after discharge from the hospital, it can be costly and disruptive—and is often preventable. While some readmissions are unavoidable due to worsening illness, appropriate transitional care and discharge procedures can reduce the risk of readmission.[12]

Rehospitalization rates are particularly high among vulnerable populations—i.e., older adults, individuals of low socioeconomic status (such as those dually eligible for both Medicare and Medicaid), and those with multiple comorbidities and disabilities. For this reason, institutions that serve these populations are disproportionately affected by costly readmissions.[13]

A statistical analysis using the 2010–2016 Nationwide Readmissions Database (NRD) revealed that the rate of 30-day all-cause readmissions in 2016 was 13.9% among all patients aged ≥1 years and 17.1% among those with Medicare.[14] A similar analysis of 2011 readmissions data from the Healthcare Cost and Utilization Project (HCUP) showed that total all-cause 30-day readmission rates were associated with an estimated $41.3 billion in total hospital costs in the study population—i.e., Medicare beneficiaries aged ≥65 years and individuals aged 18–64 years who were privately insured, uninsured, or covered by Medicaid.[15]

Suboptimal care transitions are at the root of most adverse events that arise post-discharge,[16] and estimates suggest that as many as 12% of readmissions are potentially avoidable.[17] To reduce adverse events and prevent readmissions, it is therefore critical that the clinicians accurately and promptly communicate with the patients, caregivers, and community providers during discharge planning and after discharge as appropriate.[18]

The Role of Discharge Planning

Well-thought-out discharge planning is intended to ensure an optimal transition from the hospital to the next level of care—i.e., that patients are discharged from the hospital at the appropriate time in their care and that subsequent care is properly organized.[19] CMS describes discharge planning as a process that includes elements such as[20,21]:

- Identifying at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning
- Providing a discharge planning evaluation for identified patients, or when requested by the patient, representative, or physician (best practices dictate that **all** patients should receive a discharge planning evaluation)
- Completing the evaluation in a timely manner to ensure appropriate arrangements for post-hospital care are in place before discharge and to avoid unnecessary delays

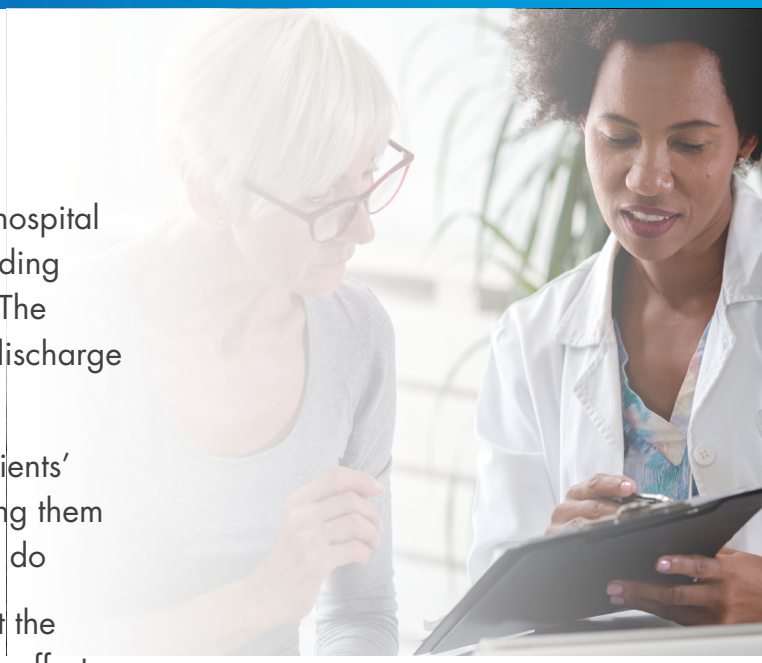
CMS describes discharge planning as a process that includes elements such as[20,21]: (continued)

- Including in the evaluation the appropriate post-hospital services needed, and the availability of such services (including, but not limited to, hospice care services, post-hospital extended care services, home health services, non–healthcare services, and community-based care providers)
- Conducting the discharge planning evaluation or developing the discharge plan under the supervision of a registered nurse, a social worker, or other qualified personnel

To be eligible to participate in the Medicare and Medicaid programs, CMS requires that hospitals and home health agencies implement discharge planning processes that[20,21]:

- Give patients and their families access to information that will help them to make informed decisions about their post-acute care
- Focus on the patient's goals of care and treatment preferences and include the patient and his or her caregivers as active partners in the discharge planning for post-discharge
- Use quality and resource measures relevant to the patient's goals and preferences to guide decisions when selecting post-acute providers
- Assist patients and families in selecting post-acute care service providers by sharing data on quality and resource use measures
- Send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving facility upon a patient's transfer
- Offer patients access to their medical records upon an oral or written request

Implementing Hospital Discharge



Discharge education is best provided throughout the hospital stay, and it is crucial that clinicians confirm understanding of the information provided on the day of discharge. The following approaches have been shown to facilitate discharge education[22-24]:

- Using the **"teach-back"** method to assess the patients' understanding of the discharge instructions by having them state in their own words what they need to know or do
- Incorporating a **discharge checklist** to document the necessary components and support interdisciplinary efforts toward a safe and successful discharge

A reduction in the risk of readmissions cannot be accomplished through pre-discharge patient education alone. Multifaceted interventions delivered by personnel dedicated specifically to care transitions in both inpatient and outpatient settings are necessary to achieve substantial improvements in readmission rates.[25]

It may not always be possible to implement high-intensity, multifaceted efforts to all patients leaving the hospital. For this reason, it may be beneficial to identify patients at highest risk of readmission who should receive targeted intervention.[25]

One example of a multifaceted discharge approach to decrease 30-day rehospitalization involves a nurse case manager who works with patients during their hospital stay to schedule follow-up appointments, confirm medication reconciliation, conduct patient education, and engage the primary care provider. Additionally, a clinical pharmacist calls discharged patients 2–4 days after leaving the hospital to reinforce the follow-up care plan and review medications.[26]

Preventing Adverse Events After Discharge

Inadequate hospital discharge can have harmful consequences for the patient.[16] A classic study found that nearly 25% of discharged patients experience adverse events within 30 days, half of which could have been prevented or ameliorated.[27] It has also been shown that adverse drug events are the most common post-discharge complication.[16]

At care transition points—e.g., hospital admission and discharge—medication errors can often be the result of regimen changes, such as the inclusion of new medications during the hospital stay.[28] Proper medication reconciliation can help prevent unintended medication discrepancies and adverse drug events—particularly in patients with low health literacy, or those with high-risk or complex medication regimens.[16]

Safe and effective transition of care requires systematic approaches to address typical challenges associated with hospital discharge[28]:

- **Improve physician information transfer and continuity**—Particular attention should be given to the content, format, and timely delivery of discharge information. Discharge summaries should encompass: diagnoses, abnormal physical findings, important test results, discharge medications, follow-up arrangements made and appointments that still need to be made, counseling provided to the patient and family, and tests still pending at discharge.
- **Reconcile medications**—Obtain a complete medication history from patients and caregivers to identify and correct any discrepancies as appropriate. Communicate complete and accurate medication information to the next provider, including indications for new medications and reasons for any changes. When possible, partner with clinical pharmacists to facilitate this process.
- **Provide adequate medical and social support**—A multidisciplinary discharge planning team—e.g., nurse case manager, social worker, pharmacist, and other healthcare providers—can facilitate proper assessments of the social needs of patients and caregivers. This team might also suggest home health services to supplement available medical support or decide that discharge to a rehabilitation or skilled nursing facility is more appropriate.

Safe and effective transition of care requires systematic approaches to address typical challenges associated with hospital discharge[28]: (continued)

- **Improve physician–patient communication**—Focus discharge counseling on the few key points that are of the greatest interest and the most importance to patients, such as major diagnoses, medication changes, dates of follow-up appointments, self-care instructions, and whom to contact if problems develop. These key instructions should be reinforced by other hospital staff, including nurses and pharmacists.

Resources to Support Discharge Planning

Pfizer has created several resources designed to optimize the discharge planning process. These resources comprise both consumer and provider materials:

- Consumer materials are designed to enhance self-care and communication skills of both patients and caregivers, and assist them in understanding essential health information.
- Provider materials support building specific, evidence-based skills and using best practices shown to positively affect care transitions.

ArchiTools—Getting Ready for Discharge Toolkit

The Getting Ready for Discharge Toolkit contains the following tools and resources:

- **Discharge Guide**—A consumer brochure that introduces the goals of discharge planning and encourages patients to play an active role during their hospital stay and during the transition to home or another care setting
- **Discharge Checklist**—A shared resource to guide patients through essential information to know before leaving the hospital
- **My Medicines Form**—A fillable form patients can use to track key details about the medicines they take, along with contact information for healthcare providers and pharmacies
- **How to Use the My Medicines Form**—Provides patients with instructions on how to use the My Medicines Form
- **Guide to Using the Teach-Back Method**—A guide for healthcare providers with a background and step-by-step instructions on using the teach-back method to enhance patient and caregiver understanding of information related to the discharge process

Other Resources to Support Discharge Planning

Below is a list of additional Pfizer resources available to ensure the best possible care transitions:

- **Care Transitions Toolkit**—A set of resources designed to help inform and enhance care transitions as part of efforts to drive quality across the healthcare continuum
- **Medication Reconciliation Toolkit**—A compendium of resources designed to support the implementation or augmentation of a medication reconciliation program
- **Making the Most of Your Medical Appointment Toolkit**—A set of resources designed to empower patients to make the most of the time spent with a practitioner
- **Skills for Promoting and Empowering Patients Toolkit**—A set of resources that reviews patient empowerment and communication techniques to promote behavior change and mastery of self-management skills
- **Staying Healthy brochures**—Educational brochures designed to help adults make informed choices about healthy lifestyle habits and preventive services

References

1. Agency for Healthcare Research and Quality (AHRQ). Hospital Readmissions. Accessed June 11, 2021. https://www.ahrq.gov/topics/hospital-readmissions.html
2. American Medical Association. Quality ID #356: Unplanned Hospital Readmission Within 30 Days of Principal Procedure. Centers for Medicare & Medicaid Services. Accessed June 11, 2021. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_356_MIPSCQM.pdf
3. Centers for Medicare & Medicaid Services. Performance Year 2020 MIPS Quality Performance Category: Measure Information for the 30-Day All-Cause Hospital Readmission Measure November 2020. Accessed June 11, 2021. https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1200/2020%20MIPS%20All-Cause%20Hospital%20Readmission%20Measure.zip
4. Centers for Medicare & Medicaid Services. 2021 APM Performance Pathway (APP) for MIPS APM Participants. Accessed June 11, 2021. https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1495/2021%20APM%20Performance%20Pathway%20%28APP%29%20Toolkit.zip
5. Centers for Medicare & Medicaid Services. Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. Accessed June 11, 2021. https://www.cms.gov/files/document/2022-announcement.pdf
6. National Committee for Quality Assurance (NCQA). Plan All-Cause Readmissions (PCR). Accessed June 11, 2021. https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/
7. Centers for Medicare & Medicaid Services. Hospital Inpatient Quality Reporting (IQR) Program Measures. Accessed June 11, 2021. https://qualitynet.cms.gov/inpatient/iqr/measures
8. US Department of Health & Human Services (HHS). FY 2021 Annual Performance Plan and Report – Goal 1 Objective 2. Expand Safe, High-Quality Healthcare Options, and Encourage Innovation and Competition. Accessed June 11, 2021. https://www.hhs.gov/about/budget/fy2021/performance/performance-plan-goal-1-objective-2/index.html#table
9. Centers for Medicare & Medicaid Services. MIPS Improvement Activities Quick Start Guide. Accessed June 11, 2021. https://qpp.cms.gov/mips/improvement-activities?py=2021
10. Centers for Medicare & Medicaid Services. MIPS 2021 Improvement Activities List. Accessed June 11, 2021. https://qpp.cms.gov/mips/explore-measures?tab=improvementActivities&py=2021#measures
11. Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program (HRRP) Measures. Accessed June 11, 2021. https://qualitynet.cms.gov/inpatient/hrrp/measures
12. Centers for Medicare & Medicaid Services. Quality Measures Fact Sheet: Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789). Accessed June 11, 2021. https://innovation.cms.gov/files/fact-sheet/bpciadvanced-fs-nqf1789.pdf
13. Barnett ML, Shu J, McWilliams JM. Patient characteristics and differences in hospital readmission rates. *JAMA Intern Med*. 2015;175(11):1803-1812. doi:10.1001/jamainternmed.2015.4660
14. Bailey MK, Weiss AJ, Barrett ML, Jiang HJ. Statistical Brief #248: Characteristics of 30-day All-Cause Hospital Readmissions, 2010–2016. Agency for Healthcare Research and Quality (AHRQ). Accessed June 11, 2021. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.pdf
15. Hines AL, Barrett ML, Jiang HJ, Steiner CA. Statistical Brief #172: Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. Agency for Healthcare Research and Quality (AHRQ). Accessed June 11, 2021. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf
16. Agency for Healthcare Research and Quality (AHRQ). Readmissions and Adverse Events After Discharge. Accessed June 11, 2021. https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge
17. McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. *Circulation*. 2015;131(20):1796-1803. doi:10.1161/CIRCULATIONAHA.114.010270
18. Agency for Healthcare Research and Quality (AHRQ). Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Accessed June 11, 2021. https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html
19. Shepperd S, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL. Discharge planning from hospital to home. *Cochrane Database Syst Rev*. 2013;(1):CD000313. doi:10.1002/14651858.CD000313.pub4
20. Cesta T. The conditions of participation for discharge planning: current rules and 2020 updates. *Hosp Case Manag*. 2020;28(3):1-5.
21. Centers for Medicare & Medicaid Services. Medicare and Medicaid programs; revisions to requirements for discharge planning for hospitals, critical access hospitals, and home health agencies, and hospital and critical access hospital changes to promote innovation, flexibility, and improvement in patient care *Fed Regist*. 2019;84(189):51836-51884. Accessed June 11, 2021. https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20732.pdf

22. Agency for Healthcare Research and Quality (AHRQ). Discharge Planning and Transitions of Care. Accessed June 11, 2021. https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care
23. Agency for Healthcare Research and Quality (AHRQ). Health Literacy Universal Precautions Toolkit, 2nd Edition. Accessed June 11, 2021. https://www.ahrq.gov/sites/default/files/publications/files/healthlittoolkit2_0.pdf
24. Soong C, Daub S, Lee J, et al. Development of a checklist of safe discharge practices for hospital patients. *J Hosp Med*. 2013;8(8):444-449. doi:10.1002/jhm.2032
25. Kripalani S, Theobald CN, Anctil B, Vasilevskis EE. Reducing hospital readmission: current strategies and future directions. A*nnu Rev Med*. 2014;65:471-485. doi:10.1146/annurev-med-022613-090415
26. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. *Ann Intern Med*. 2009;150(3):178-187. doi:10.7326/0003-4819-150-3-200902030-00007
27. Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital. *CMAJ*. 2004;170(3):345-349.
28. 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(5):314-323. doi:10.1002/jhm.228