Strategies for Improving the Discharge Process

Multidisciplinary planning and effective communication among healthcare staff are major requisites to mitigating risks in the discharge process that can lead to adverse outcomes, readmission, and mortality.[1] A well-planned and thorough discharge ensures that patients, families, caregivers, and receiving facilities are given accurate and complete information for the next phase of treatment or recovery. During discharge, the healthcare team may establish expectations with the patient, share pertinent medical information, and arrange support services.

However, one of the risks associated with discharge is readmission, a critical determining factor in patient outcomes, according to the Centers for Medicare & Medicaid Services (CMS).[2] CMS has established the Hospital Readmissions Reduction Program to help healthcare organizations improve discharge practices by linking reimbursement to the quality of hospital care. As part of the program, CMS collects data on patient outcomes and unplanned readmissions occurring within 30 days of discharge.[3]

To prevent readmission, healthcare facilities should assess their discharge processes as part of their risk management programs. This checklist contains elements of an effective discharge process; healthcare leaders can compare these strategies with their facilities' processes to pinpoint any aspects needing enhancement or modification.[4]

	Yes	No
Does your facility have a clear understanding of patients' rights, including federal civil rights laws, and do patient rights include discharge criteria?	☐	☐
Did your facility's medical staff provide input on discharge planning policies and procedures prior to review and approval by the organization's governing body?	☐	☐
• Was input from patients, other healthcare facilities, and healthcare professionals who provide care to discharged patients also included in those policies and procedures?	☐	☐

	Yes	No
Has your facility established a transitional care room or a discharge lounge — i.e., a dedicated area for the healthcare team to oversee care transitions?	☐	☐
Does your facility use technology as part of the discharge process, such as clinical workflow solutions or a clinical communication and collaboration platform?	☐	☐
Does your facility employ hospital discharge planning tools to improve transitions to postacute care settings and reduce admissions?	☐	☐
Has your facility developed collaborative partnerships with postacute care providers to improve care transitions and support better patient outcomes?	☐	☐
Does multidisciplinary collaboration, coordination, and communication occur from admission through discharge?	☐	☐
Do healthcare providers conduct comprehensive risk assessments during patients' hospital stays to identify and address any risk factors for discharge?	☐	☐
Do healthcare providers ensure that patients understand the medical or surgical reasons for their hospital stay and for the care they received?	☐	☐
Do healthcare providers use a communication technique, such as teach-back, to ensure that patients have a clear understanding of their medical conditions and what should be done to continue care as an outpatient after leaving the facility?	☐	☐
Do healthcare providers explain the potential side effects as well as warning signs and symptoms for medications prescribed to patients?	☐	☐
Are patients asked if they are able to pick up and pay for their prescriptions, or does the facility fill patients' prescriptions and have them available at discharge?	☐	☐
Are patients given the written name, address, and phone number of the healthcare provider responsible for their care while an inpatient?	☐	☐
Do healthcare providers inform patients of any pending lab work or tests that need to be checked at discharge?	☐	☐
Does your facility confirm with patients that they have transportation to go home?	☐	☐
Does a social worker or a case worker consult with patients before discharge?	☐	☐

	Yes	No
Does your facility offer or arrange community support services for discharged patients?	☐	☐
If a language barrier exists, do medical translators (either onsite or via a phone service) consult with patients to deliver discharge instructions?	☐	☐
Do discharge policies require providers to take patients' vital signs during the discharge process?	☐	☐
Do patients receive a discharge summary in their preferred language?	☐	☐
Does the discharging healthcare provider contact the patient's primary care provider and/or send a discharge summary to that provider?	☐	☐
Does your facility ensure that any follow-up outpatient visits or home healthcare services are scheduled for patients?	☐	☐
Does your facility follow up with patients via phone within 24 to 72 hours after their discharge?	☐	☐
If patients refuse to participate in discharge planning, do healthcare providers document the refusal in patients' health records?	☐	☐
Do all staff members receive training on your facility's care transition and discharge processes?	☐	☐
Does a quality improvement committee or a medical record review committee examine cases of hospital readmission within 30 days to identify what potentially could have been avoided?	☐	☐
Are readmission case review findings implemented through your facility's quality and peer review processes?	☐	☐
Does your facility collect data on compliance with transition measures to evaluate its discharge program's effectiveness and goals?	☐	☐
Are patients surveyed about the quality of their discharge experience as well as their knowledge and understanding of their medical condition and outpatient treatment plans?	☐	☐

Endnotes

[1] Kaplan, E., & Lien, D., (2023, January 17). *The hospital discharge process: A review of its main barriers and quality improvement strategies.* Thinq at UCLA. Retrieved from https://thinq.medium.com/the-hospital-discharge-process-a-review-of-its-main-barriers-and-quality-improvement-strategies-65a702bf87f8

[2] Centers for Medicare & Medicaid Services. (2023, February 23). Hospital Readmissions Reduction Program (HRRP). Retrieved from www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program

[3] Centers for Medicare & Medicaid Services. (2022, August 8). Hospital Readmissions Reduction Program (HRRP) FAQs. Retrieved from www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program

[4] Guidance in this publication is adapted from the following resources: The Sullivan Group. (n.d.). *Discharge instructions for patients: Best practices*. Retrieved from https://blog.thesullivangroup.com/discharge-instructions-for-patients-best-practices; University of Southern Maine. (2021, August 24). *Improving discharge procedures for better patient outcomes*. Retrieved from https://online.usm.maine.edu/degrees/healthcare/msn/nursing-administration-leadership/improving-discharge-procedures/