Person and Family Engagement (PFE) Implementation Guide for Hospitals

PFE Practice 2: Discharge Planning Checklist

Introduction

Meaningful person and family engagement (PFE) at multiple levels (i.e., point of care, policy and protocol, and governance) helps hospitals address what matters most to patients and families, and it improves hospitals' ability to achieve long-term improvements in quality and safety. This guide provides hospital leaders and staff with practical, step-by-step guidance to successfully implement PFE Practice 2: Discharge Planning Checklist, one of five PFE best practices in the CMS-funded Hospital Quality Improvement Contract (HQIC) program (see Exhibit 1). For more detailed information about PFE and the five PFE best practices, please refer to the Hospital Roadmap for Person and Family Engagement: Achieving the five PFE best practices to improve patient safety and health equity.

Exhibit 1. Five Practices for Patient and Family Engagement

SOURCE: Centers for Medicare and Medicaid Services (2020)

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PATIENT SAFETY

Invite and empower patients and families to speak up before discharge about anything that does not feel or look right. Help them know what to look for to avoid a readmission: Are they aware of how to take their medication? Do they know what symptoms should be brought to the attention of their provider?

PFE Practice 2 Definition

At least one unit at the hospital has a physical discharge planning checklist that is discussed with every patient prior to discharge. The checklist can be a stand-alone document or integrated into other discharge papers.

Intent of PFE Practice 2

Patients and their care partners should be included as full partners in the discharge planning process so that they understand how to successfully continue their recovery after they leave the hospital. The practice focuses on the use of the checklist by a physician, discharge staff, or other healthcare professional to guide a conversation with patients and care partners about being discharged prior to leaving the hospital. Ideally, patients and families also receive a physical copy of the checklist.

While there is not a standard checklist that must be used by all hospitals, the checklist should facilitate conversation about topics such as:

- What life at home will be like (e.g., foods and activities to avoid)
- Medications (e.g., purpose of each medicine, what and how to take it, and potential side effects)
- Warning signs and problems and who to contact if there is a problem
- Test results, either explaining them or letting the patient know when they should hear about results and whom to call if they don't get the results
- Follow-up appointments, including offering to schedule them.

Hospitals should focus on the intent of this practice. The checklist is a tool that hospitals can use to facilitate a conversation with the patient at discharge. The conversation is the most important, specifically the invitation to partnership.

Benefits of PFE Practice 2

The discharge planning checklist invites and encourages patients and their care partners to participate in the discharge planning process by sharing and receiving information and asking questions. When used effectively, the checklist facilitates

both listening and the sharing of information by the patient and hospital staff. The checklist provides an invitation for patients and families to partner with the discharge planning team to reduce complications post-discharge, including adverse drug events and hospital-acquired infections. By engaging patients and families prior to discharge, the hospital gains extra sets of eyes and ears to help reduce preventable errors and readmissions.

Five Suggested Steps to Implement PFE Practice 2

1. **Secure support and buy-in from leaders and hospital staff**
2. **Create or adapt a draft checklist**
3. **Pilot the checklist in one unit or department for a defined period of time**
4. **Identify opportunities for improvement and refine the checklist**
5. **Expand use of the checklist and evaluate for continuous improvement**

We recommend using the Plan-Do-Study-Act (PDSA) cycle to implement PFE Practice 2. PDSA is a method to test a change that is implemented by creating a plan, testing the plan, observing and learning from the test, and determining what modifications are needed to improve the outcome. For more information on the PDSA cycle, visit the Institute for Healthcare Improvement's website.

Step 1. Secure support and buy-in from leaders and hospital staff

Securing support and buy-in from leaders and hospital staff is the first step in developing a plan to implement (or do) and study the PFE practice.

- **Get commitment from leaders.** Discuss with leaders the importance and benefits of engaging patients and their care partners (including those who represent vulnerable populations) in discharge planning. Educate leaders about how you plan to implement and evaluate this new process and the resources needed. Invite them to provide input and participate in planning, piloting, and evaluating the practice.
- **Determine and secure the resources needed for your hospital.** Resources needed to implement a discharge planning checklist may vary depending on your hospital's size and characteristics. Be sure to consider resources for the point

person, for trainers to prepare and conduct staff training, and for scheduling and conducting discharge planning meetings. Also be sure to budget for developing and providing printed materials to patients and staff.

- Work with physicians, nurses, and staff to obtain their input about patient safety needs that could be addressed in the discharge checklist. This could include information about what life at home will be like, medications, warning signs and who to contact if there is a problem, test results, and follow-up appointments. Define process and outcome measures of success, such as HCAHPS scores or readmission rates.
- Educate clinicians and staff about the benefits of using the checklist to facilitate a conversation with patients and families before being discharged. Remind them that engaging the patient—and their family members—as partners in their care contributes to a better experience and better health outcomes.

Step 2. Create or adapt a draft discharge checklist

Another important step in developing a plan is to create or adapt a draft checklist that uses patient- and family-friendly language. Creating the checklist in partnership with patients and families—and with administrative and clinical leaders—also helps to secure buy-in for the practice.

- Create or adapt an existing checklist that invites the patient to be a partner in their care to help ensure patient safety after discharge. The checklist and conversation should address issues that the hospital and the patient—and their family—need to think about after a hospital stay. Examples of discharge discussion checklists are available at the end of this guide.
- **Partner with patient and family advisors to provide input on the draft checklist.** Circulate the draft checklist with your Patient and Family Advisory Council or Committee. Ask them to provide input on the questions being asked to make sure they are easily understood by patients and address patient and family concerns.
- **Review the draft checklist with clinical and administrative staff**. Make sure that the topics and questions are useful and cover relevant patient safety concerns. This step helps gain buy-in and support from those who will use the checklist.
- **Consider how and when to provide the checklist to patients and their care partners.** Your hospital may wish to provide copies of the checklist or notes from the discussion can be printed and sent home with the patient or caregiver. Consider making the checklist available on the hospital's website and other

convenient places the patient can access, such as through a patient portal. If the patient needs a language interpreter, provide this before the discussion.

Step 3. Pilot the checklist in one unit or department for a defined period of time

Implement your plan by piloting the checklist in one unit or department for a defined period of time. Be sure to collect data during the pilot so that you can study and measure changes that result from using the checklist.

- **Decide where in your hospital you want to begin using the checklist.** For example, if your hospital routinely performs knee or hip replacement surgeries, you may want to begin using the checklist with those patients. An important factor in selecting a unit or department for the pilot is the belief in—and commitment to—meaningful person and family engagement among leaders, clinicians, and staff.
- **Train staff to use the checklist with patients and families**. Consider asking patient and family advisors to practice the teach-back method, where patients and their care partners repeat back instructions or information in their own words, with clinicians and staff or present during a lunch-and-learn workshop. This may help nurses and discharge staff get more comfortable with discussing the topics in the checklist, and it provides an opportunity for real-time feedback from the patient and family advisors. Provide a script or talking points to aid staff in preparing for and having these conversations. As with any new process, make sure to address questions or concerns raised by staff.
- **Identify how you will measure success and collect data.** For example, your hospital may want to conduct pre- and post-implementation surveys; monitor HCAHPS scores or readmission rates before and after implementation.
- **Gather feedback from key stakeholders on the new process.** Get feedback from clinicians, nurses, hospital leaders, patient and family advisors, as well as patients. Conduct periodic observations to ensure the checklist is being used as intended.

Step 4. Identify opportunities for improvement and refine the checklist

Study your data to identify what works well and what needs to be improved. Make any necessary adjustments to the checklist and the processes used to share and discuss the checklist.

- **Refine the process as needed.** Use iterative feedback from nurses, patients, and their families and caregivers to identify opportunities for improvement and refine

the checklist and the processes used to share and discuss the checklist. Encourage brainstorming among staff to problem solve any reoccurring issues or challenges.

- **Prepare for hospital wide implementation.** Identify and train champions in each of the remaining units that will utilize the process. Consider and prepare for challenges that may arise in other clinical areas.

Step 5. Expand use of the checklist and evaluate for continuous improvement

Implement the checklist and related processes again. Be sure to periodically evaluate to identify lessons learned and make improvements as needed.

- **Expand use of the discharge planning checklist to other units.** Remember, the goal is to use the checklist to have a conversation with every patient before or at discharge to help reduce post-discharge complications.
- **Evaluate implementation.** Create a plan for monitoring use of the checklist over time. Adapt the checklist as needed to address issues or concerns that arise during conversations. Consider placing a "feedback box" in the waiting room or gathering feedback from patients and families during the discharge process and follow-up calls. Track and compare the predefined measures of success over time, including HCAHPS scores before and after implementation to determine whether the discharge planning checklist made a difference in patients' experiences and satisfaction.

When to Report "Yes, Our Hospital is Meeting PFE Practice 2"

Hospitals meet the practice if they have a physical discharge planning checklist for patients, preferably one that is designed or at least reviewed by patients and families. Prior to discharge, hospital staff discuss the checklist with patients and/or their care partners.

Lessons From the Field: Advocate Trinity, Chicago, Illinois

Advocate Trinity Hospital in Chicago, IL implemented IDEAL Discharge Planning — which includes discussing a checklist with patients and their care partners — in its 29-bed medical surgical unit as part of a larger effort to reduce hospital readmissions. Trinity provided the Be Prepared to Go Home Checklist and Booklet to patients at admission. Nurses and staff encouraged patients and care partners to read the booklet and ask questions throughout their stay. Nurse assistants helped patients write their

questions in the booklet. Nurses reviewed the checklist and booklet with patients and family members prior to discharge. They were also required to keep track of key tasks in the discharge planning process in a separate system-wide tool.

All unit staff and nurses were educated about the upcoming changes, and some nurses received a 6-hour training on the new discharge planning process. These nurses then trained other nurses in small, 1-hour group sessions. Once implemented, nurse managers asked patients and families about their experiences participating in the discharge planning process and shared this feedback with the nurses.

Twelve months after the hospital began using the checklist as part of IDEAL Discharge Planning, HCAHPS scores consistently increased, particularly for measures related to discharge and communication with doctors; previously scores related to discharge had been in the single digits. Nurses were also more aware of patients' needs and concerns related to discharge.

Resources for Implementation of PFE Practice 2

- Be Prepared to Go Home Checklist and Booklet, Guide to Patient and Family Engagement in Hospital Quality and Safety (Agency for Healthcare Research and Quality): https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html
- Your Discharge Planning Checklist (Centers for Medicare & Medicaid Services): https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf
- My Information Post-Discharge Patient Tool (National Patient Safety Foundation): https://www.wickhosp.com/wp-content/uploads/2016/02/Post-Discharge-Tool.pdf

Sources for this guide include the following:

- Guide to Patient and Family Engagement to Improve Hospital Quality and Safety (2013). Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook. Agency for Healthcare Research and Quality: Rockville, MD.