# Transitions of Care:
## AHRQ IDEAL DISCHARGE OVERVIEW

Readmission to the hospital within 30 days of discharge can result in adverse patient outcomes, lower customer service scores and readmission penalties, and is often avoidable. The Agency for Healthcare Research and Quality (AHRQ) IDEAL Discharge Toolkit, AHRQ IDEAL Discharge Planning, remains as relevant in today's environment as it was when first released in 2013. It focuses on the key strategy of fully engaging patients, families and care partners in all aspects of planning before the actual discharge and the first two weeks at the next level of care.

Utilize the AHRQ IDEAL Discharge Planning implementation toolkit, resources and guides to develop or enhance your existing care transitions program.

### What's included in an IDEAL Discharge?

There are FIVE key elements of the AHRQ IDEAL Discharge to help your facility educate and empower patients, families, and care partners to be fully engaged in their discharge plan beginning on the day of admission.

**I – Include** the patient, family and identified care partners.

**D – Discuss** the five key areas:

1. Description of what to expect with the next level of care.
2. Review medications.
3. Highlight readmission risk factors.
4. Explain test results.
5. Make follow-up appointments.

**E – Educate** in plain language.

**A – Assess** understanding of diagnosis, condition, discharge process, and next steps utilizing teach-back.

**L – Listen** to and honor goals, preferences, observations and concerns, focusing on areas that impact an individual's ability to remain in the community.

The IDEAL Discharge Strategy is part of the AHRQ Guide to Patient and Family Engagement in Hospital Quality and Safety. It can be used on its own by hospitals, skilled nursing facilities and/or home health agencies in conjunction with other initiatives, including Reengineering Discharge (RED), the Care Transitions program, and **BOOST**ing (Better Outcomes for Older Adults Through Safe Transitions) Care Transitions.

### Sample tools in the toolkit include:

1. Implementation Handbook
2. Be Prepared To Go Home Checklist and Booklet
3. IDEAL Discharge Planning Overview, Process, and Checklist
4. Improving Discharge Outcomes with Patients and Families

### Tips:

1. Follow a patient from admission to discharge to observe your current process.
2. Learn from your interdisciplinary team (including frontline staff) the steps in your current process and their ideas for improving the customer and staff experience with discharge planning.
3. Call a recently discharged patient or two and ask them to describe their journey.
4. Establish your project team and share what you learned.

For coaching and mentoring support in implementing the AHRQ IDEAL Discharge, contact Melody Brown at Melody.Brown@AlliantHealth.org.

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