Implementing the IDEAL Discharge
Step 1: Form a Multidisciplinary Team and Examine Current Your Process

Presented by:
Amy Daly, MA, LNHA

February 2023

ALLIANT HEALTH SOLUTIONS
QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Amy Daly, MA, NHA

SENIOR QUALITY IMPROVEMENT SPECIALIST

Amy Daly is a licensed nursing home administrator with over 20 years of leadership and long-term care management experience. In addition to her prior work as a vice president of long-term care and facility administrator, Amy has served on the boards of the Genesee Health Facilities Association (as treasurer and education committee member) and the Genesee Health Facilities Foundation. Amy serves as a New York State Department of Health Informal Dispute Resolution (IDR) panel member and has been an adjunct clinical instructor of dental hygiene at Monroe Community College. Amy has a master's degree in health promotion and a bachelor's degree in health sciences.

Email: adaly@ipro.org

Implementing the IDEAL Discharge Planning Strategy Step 1: Form a Multidisciplinary Team To Identify Areas of Improvement

Process improvement teams should be patient-centered and include the following:

- ✓ The patients' identified care partners
- ✓ Members of the interdisciplinary team
- ✓ Community partners

The Role of Patients, Care Partners and Family Advisors

The AHRQ Discharge Planning Implementation Handbook identifies strategies for engaging patients and family advisors throughout the process:

- Give feedback on what the current discharge process feels like as a patient or family member.
- Contribute to adapting the IDEAL Discharge Planning strategy and tools for your facility (both the overall process and the individual tools).
- Take part in training clinicians on the IDEAL Discharge Planning process by participating in role plays or other small group exercises or by describing how the discharge process feels to the patient or family.
- Observe clinicians throughout the hospital stay and give feedback on how they meet the key elements of the IDEAL Discharge Planning process.

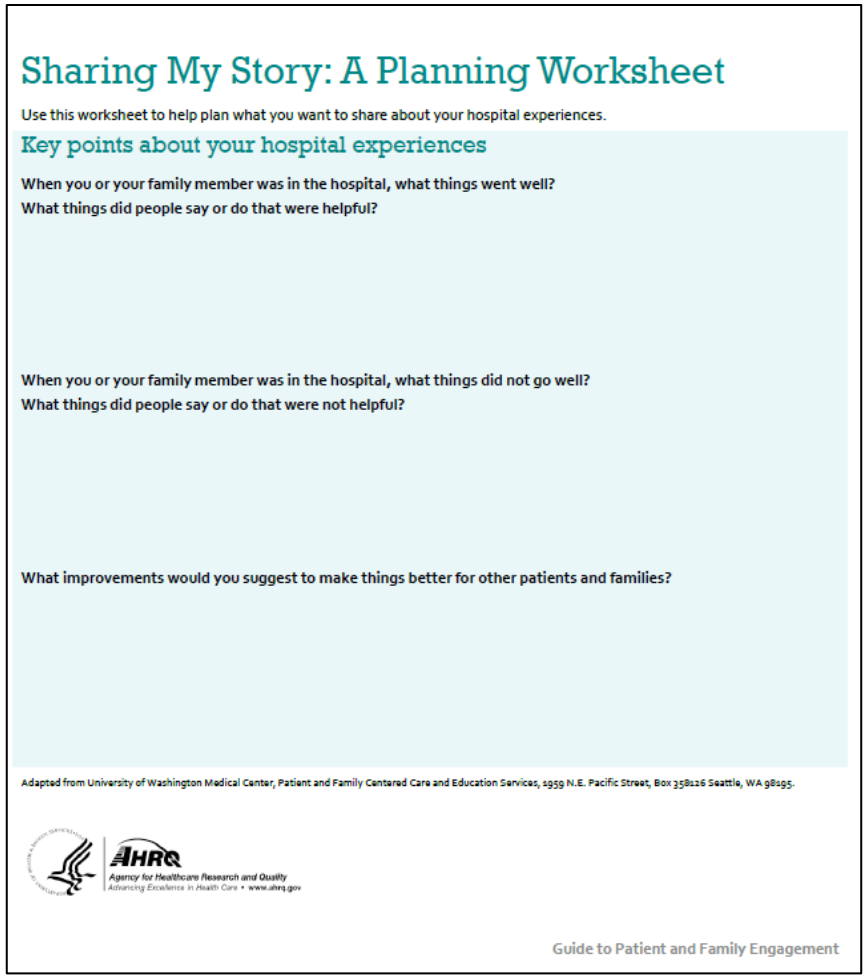
Obtaining Patient and Family Advisor Input

In addition to having patient and family advisors on your quality improvement team, consider interviewing recently discharged and readmitted patients.

When capturing the patient experience:

- Use direct quotes when possible
- Highlight unexpected findings, particularly those that deviate from your policy
- Avoid labels such as "difficult patient or family" or "non-compliant."

Sharing My Story Planning Worksheet



Sharing My Story: A Planning Worksheet

Use this worksheet to help plan what you want to share about your hospital experiences.

Key points about your hospital experiences

When you or your family member was in the hospital, what things went well?
What things did people say or do that were helpful?

When you or your family member was in the hospital, what things did not go well?
What things did people say or do that were not helpful?

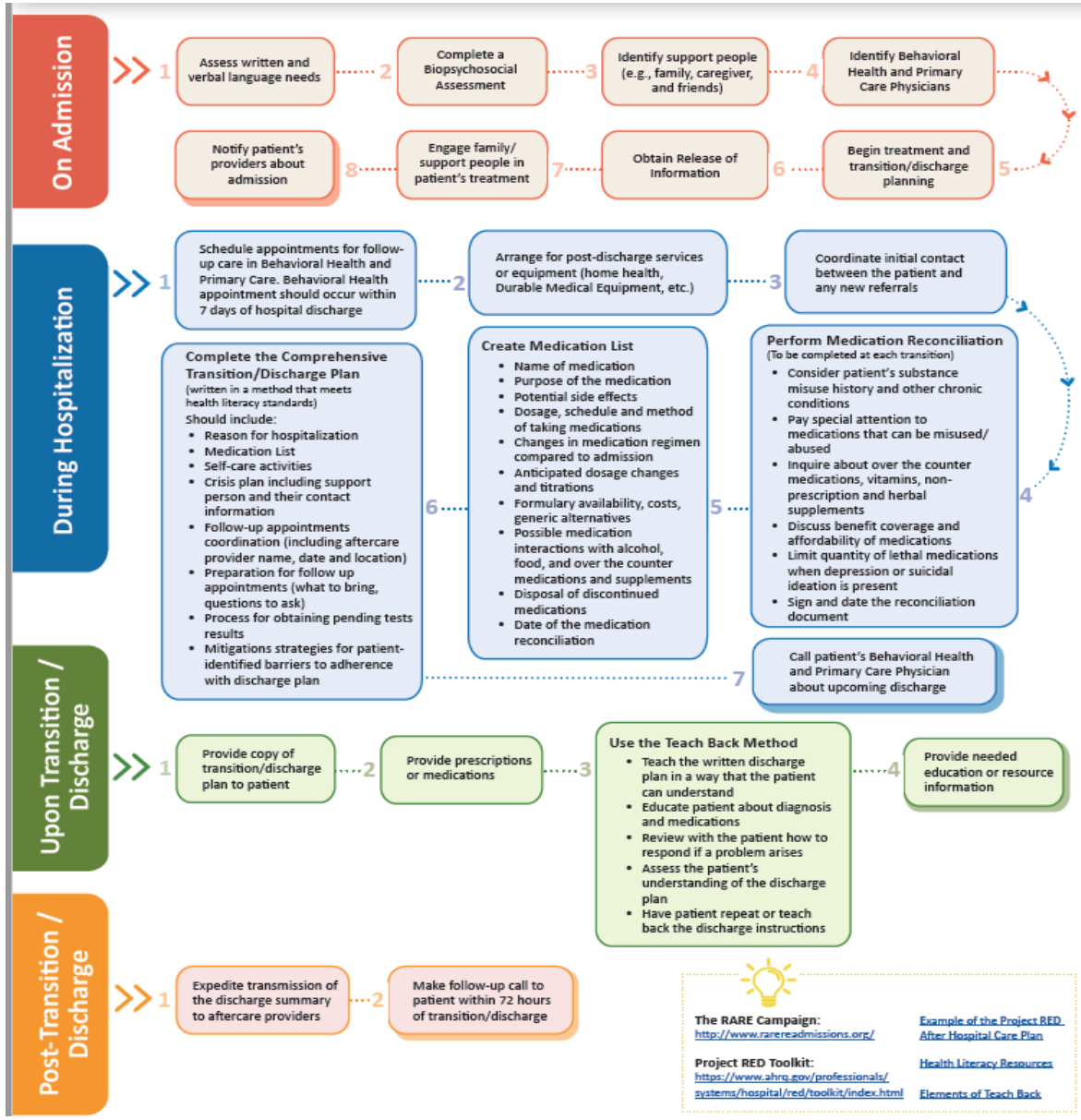
What improvements would you suggest to make things better for other patients and families?

Adapted from University of Washington Medical Center, Patient and Family Centered Care and Education Services, 1959 N.E. Pacific Street, Box 358126 Seattle, WA 98195.

AHRQ Agency for Healthcare Research and Quality

Guide to Patient and Family Engagement

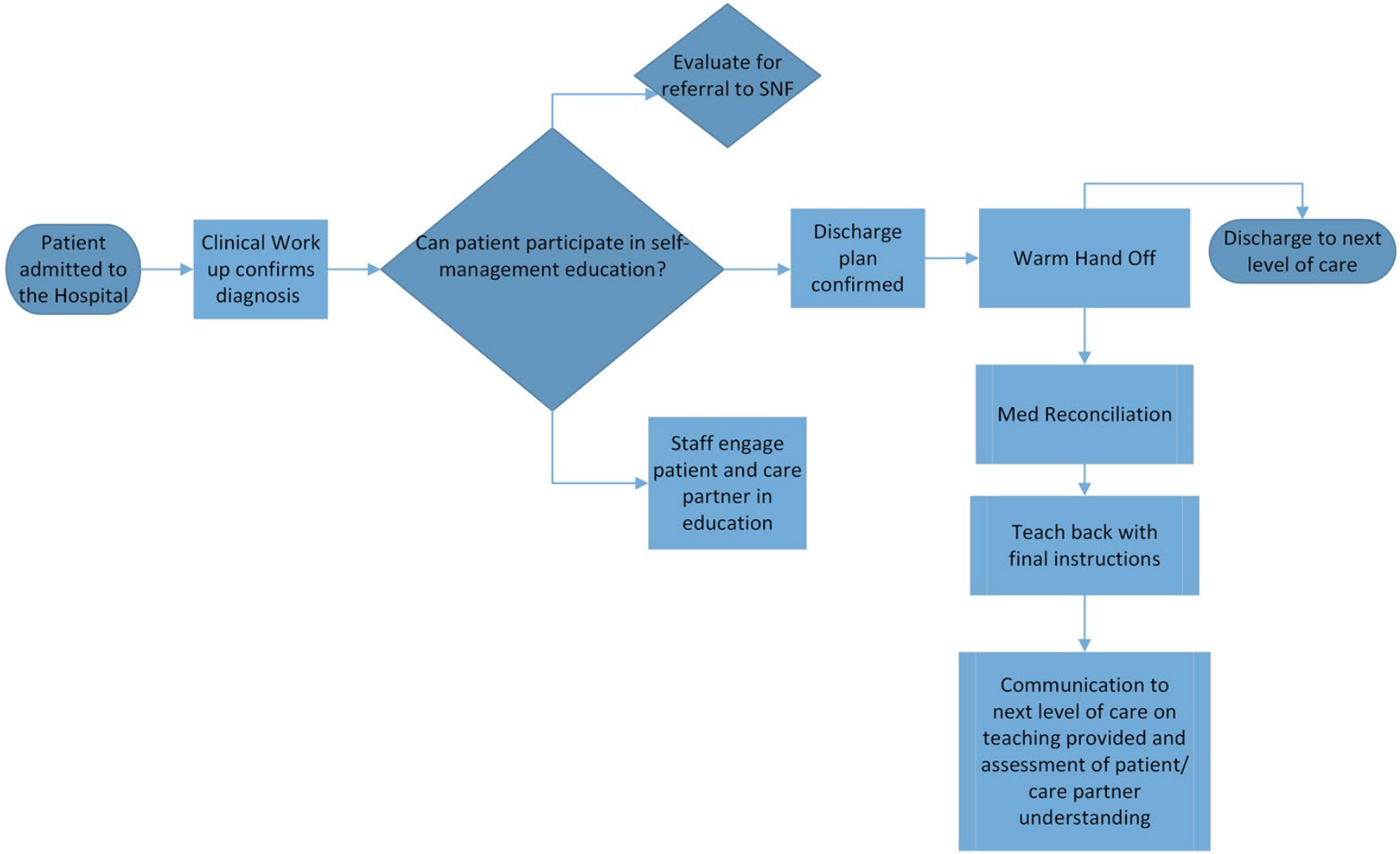
Flow or Process Mapping



[AHS Care Transition Workflow]

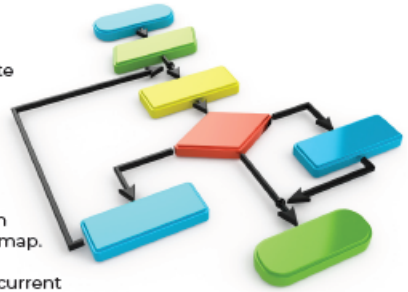
ALLIANT HEALTH SOLUTIONS | QIN-QIO Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES IQUALITY IMPROVEMENT & INNOVATION GROUP

Sample high level flow chart



Transitions of Care: PROCESS MAPPING

Why Create a Process Map?



According to the Institute for Healthcare Improvement (IHI), the rate of avoidable rehospitalizations can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management.

The first step to improving transitions is creating a visual illustration of the current process or patient journey on a flowchart or process map.

Here are tips for creating a robust process map or flowchart of the current system or patient journey:

1. Establish your team. Determine if you want to develop your process map with your internal team or include cross-setting partners.
2. Provide your team with examples or training in creating a process map. Brief videos, such as the 9:47 minute University of North Carolina (UNC) Institute for Healthcare Quality Improvement step-by-step video, demonstrate the creation of a process map in a health care setting.
3. Identify the start and end points of the process you are mapping.
4. Fill in each identifiable step in the current process based on input from your team to capture what is actually happening.
5. Assign team members to research and fill in gaps.
6. Review your initial draft with frontline staff engaged in each step of the process or journey touchpoints to identify potential gaps between policy and practice. Note any workarounds staff currently do to manage gaps.
7. Interview patients and care partners with recent care transitions experience and compare their process description with your identified workflow.

Benefits of using a flow chart to assess your process:

- Clarifies complex processes.
- Identifies steps that do not add value (delays, unnecessary work, duplication, and breakdowns in communication).
- Helps team members gain a shared understanding of the process (identify problems, focus discussions, and identify resources).
- Serves as a basis for designing new processes.

ADDITIONAL TOOLS AND RESOURCES	
AHS Care Transitions Workflow Example of a mapped workflow	IHI QI flowchart IHI Flow Chart Video Training resources for creating flowcharts
CMS Beneficiary Care Activities & Transitions (cms.gov) Common Challenges for Beneficiary Care Transitions (cms.gov) Two patient care transitions journey maps based on recounted experiences of 46 Medicare beneficiaries and their caregivers.	

For coaching support to create your care transition process or journey map, contact Melody.Brown@allianthealth.org.

Reduce avoidable readmissions: IHI. Institute for Healthcare Improvement. Retrieved January 24, 2023, from https://www.ihi.org/Topics/Readmissions/Pages/default.aspx

This material was prepared by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHS-QIN-QIO-T01-NH-T01-PCH-3235-02/02/23

ALLIANT HEALTH SOLUTIONS | QIN–QIO

quality.allianthealth.org

[AHS Process Mapping Tip Sheet]

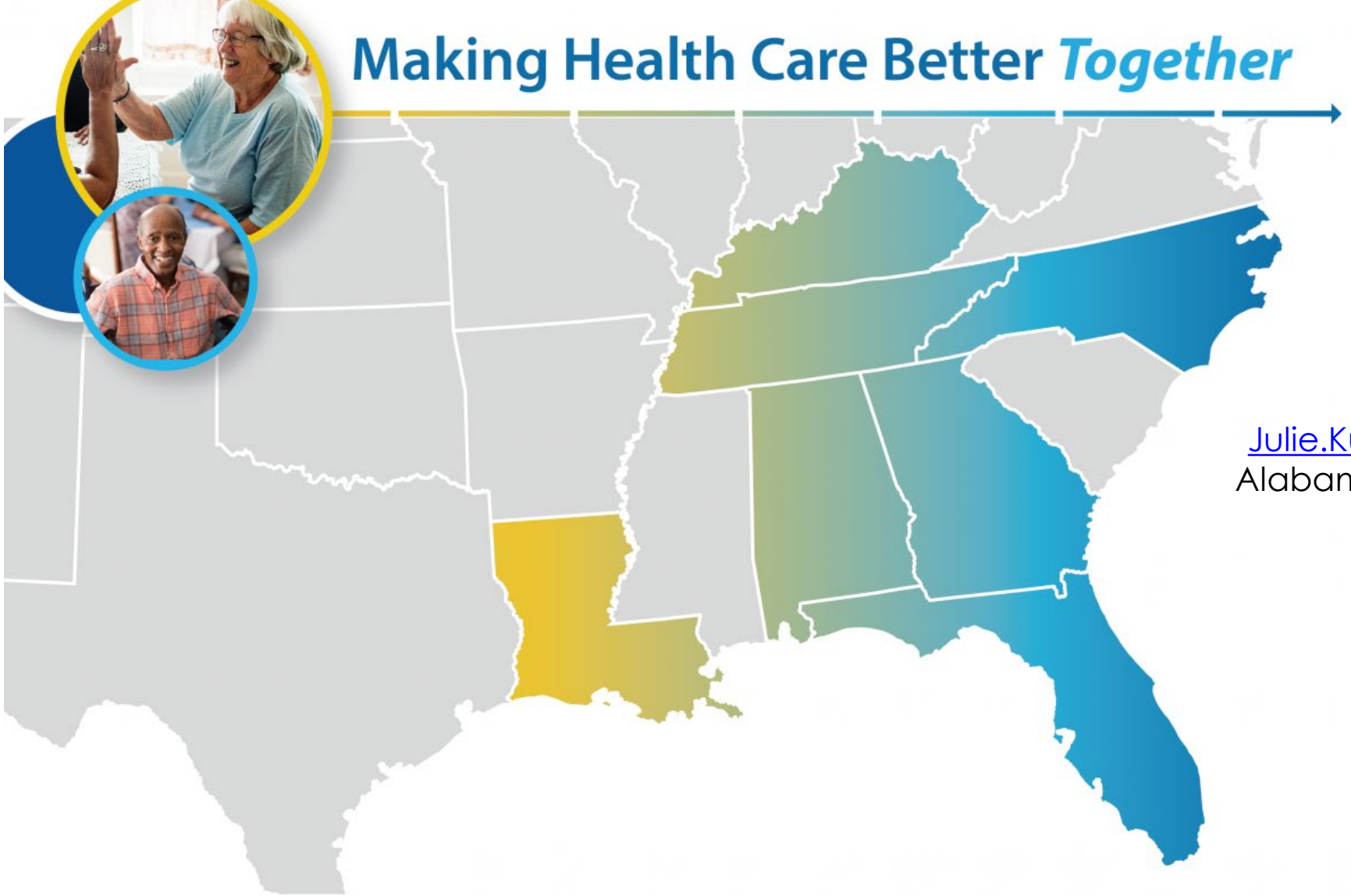
ALLIANT HEALTH SOLUTIONS | QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROUP

Summary

Form a multidisciplinary team to examine your current discharge process

Engage patients and care partners to capture their experience with the discharge process

Map your current discharge process



Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

Leighann Sauls
Leighann.Sauls@AlliantHealth.org
Georgia, Kentucky, North Carolina and Tennessee

Program Directors

ALLIANT HEALTH SOLUTIONS | QIN-QIO Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES IQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

ALABAMA • FLORIDA • GEORGIA • KENTUCKY • LOUISIANA • NORTH CAROLINA • TENNESSEE

@AlliantQIO

Alliant Health Solutions

@AlliantQIO

AlliantQIO

This material was prepared by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHS-QIN-QIO TO1-PCH--3271-02/10/23

ALLIANT HEALTH SOLUTIONS | QIN–QIO Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROU P