# Implementing the IDEAL Discharge Step 3: Implement and Evaluate Your IDEAL Discharge Strategy

Presented by:
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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. In addition, 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.

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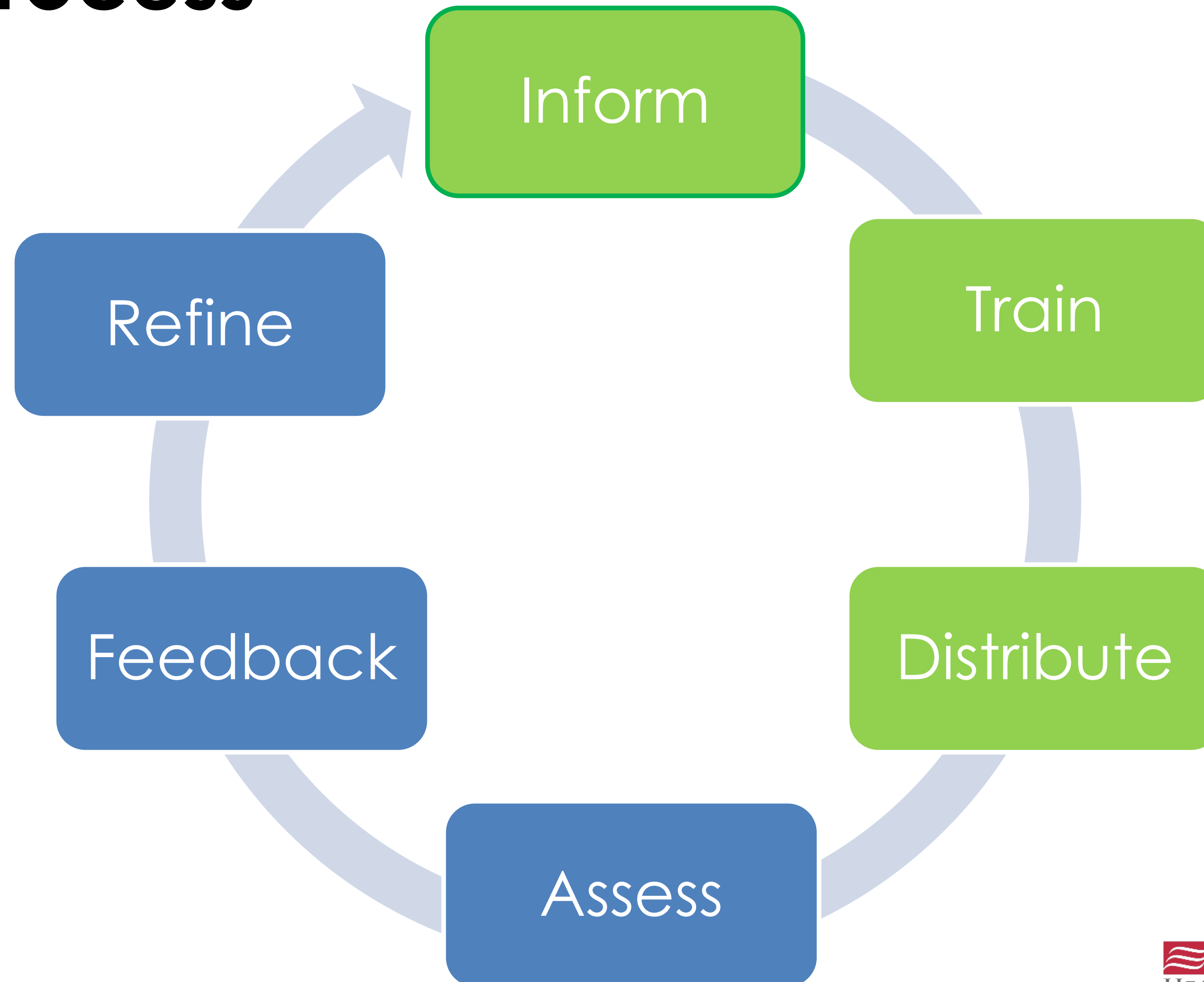
# Implementation Step 3: AHRQ IDEAL Discharge Planning Implementation Handbook

Strategy 4: IDEAL Discharge Planning (Implementation Handbook)

Care Transitions from Hospital to Home: IDEAL Discharge Planning

Implementation Handbook

# Key Elements of the IDEAL Discharge Planning Step 3 Process



# IDEAL Training Resources

## Improving Discharge Outcomes with Patients and Families

### Evidence for engaging patients and families in discharge planning

Nearly 20 percent of patients experience an adverse event within 30 days of discharge.[1,2] Research shows that three-quarters of these could have been prevented or ameliorated.[1] Common post-discharge complications include adverse drug events, hospital-acquired infections, and procedural complications.[1] Many of these complications can be attributed to discharge planning problems, such as:

- Changes or discrepancies in medications before and after discharge[3,4]
- Inadequate preparation for patient and family related to medications, danger signs, or lifestyle changes[3,4,5]
- Disconnect between clinician information-giving and patient understanding[3]
- Discontinuity between inpatient and outpatient providers[3]

Involving the patient and family in discharge planning can improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction.[6,7]

More and more, hospitals are focusing on transitions in care as a way to improve hospital quality and safety. As one indicator of this, the Centers for Medicare and Medicaid Services implemented new guidelines in 2012 that reduce payment to hospitals exceeding their expected readmission rates.

To improve quality and reduce preventable readmissions, [insert hospital name] will use the Agency for Healthcare Research and Quality's Transitions from Hospital to Home: IDEAL Discharge Planning process to engage patients and families in preparing for discharge to home.

### Key elements of IDEAL Discharge Planning

**I**nclude the patient and family as full partners in the discharge planning process.

**D**iscuss with the patient and family five key areas to prevent problems at home:

1. Describe what life at home will be like
2. Review medications
3. Highlight warning signs and problems
4. Explain test results
5. Make followup appointments

**E**ducate the patient and family in plain language about the patient's condition, the discharge process, and next steps throughout the hospital stay.

**A**ssess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

**L**isten to and honor the patient's and family's goals, preferences, observations, and concerns.

This process will include at least one meeting to discuss concerns and questions with the patient, family of their choice, and [identify staff].

### What does this mean for clinicians?

We expect all clinicians to:

- Incorporate the IDEAL discharge elements in their work
- Make themselves available to the [identify staff] who will work closely with the patient and family
- Take part in trainings on the process

**Tool 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning Training** prepares clinicians and hospital staff to support the efforts of patient and family engagement related to discharge planning.

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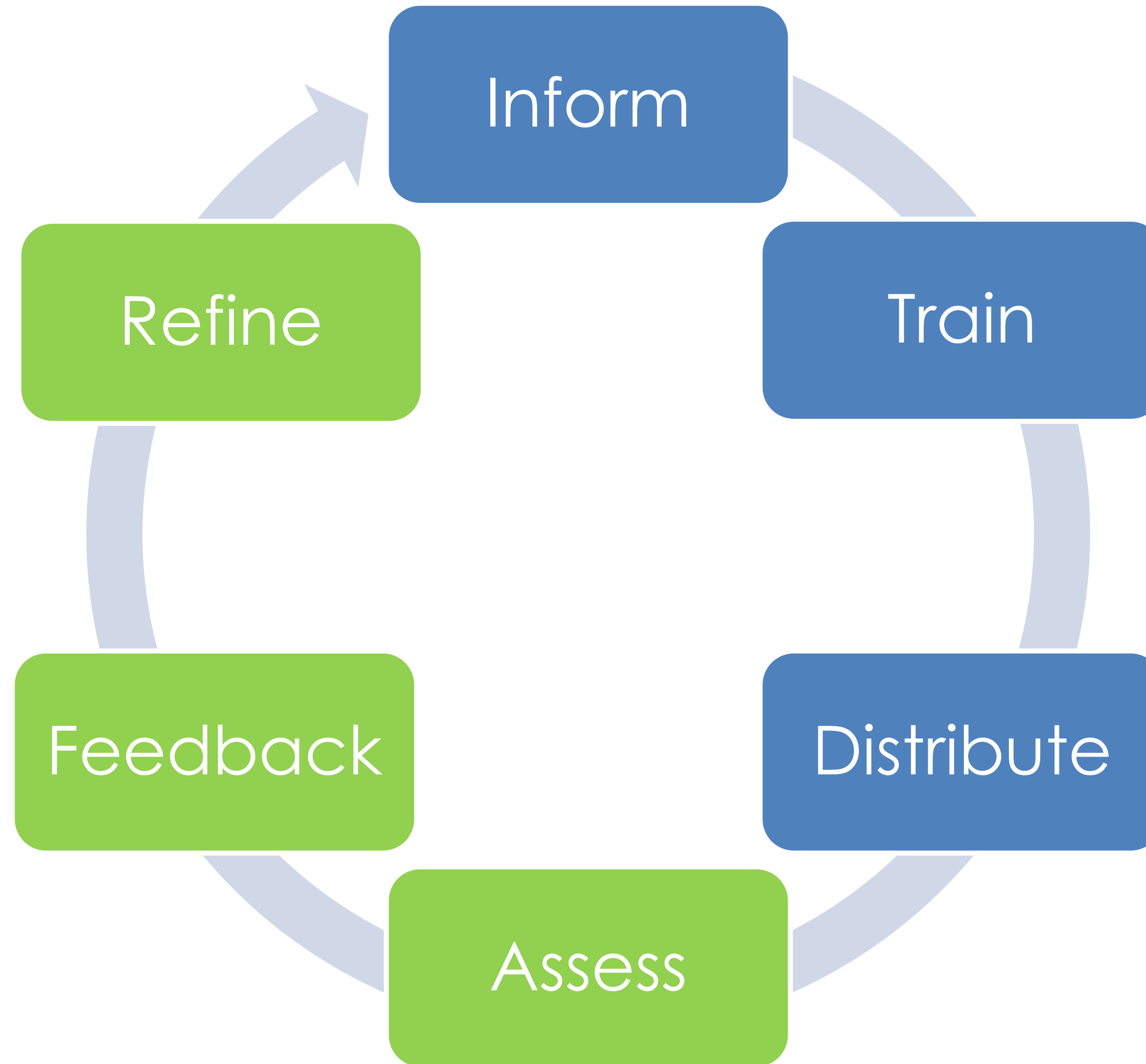
Inform
Train
Distribute
Assess
Feedback
Refine

# Alliant Health Solutions Care Transitions Tools

## Transitions of Care:
### RE-IGNITE THE WARM HANDOFF TO REDUCE READMISSIONS

**Utilize a person-centered "warm handoff" during every transition of care to reduce miscommunication and omissions that can result in medical errors and adverse events.**

**Key Information to Include for In-Person or Virtual Warm Handoffs:**

- Medication lists and last doses given
- Immunizations given and immunizations still due
- Goals of care and advance directives
- Alliant Zone Tools
- Readmission risks
- To-do action list: appointments, tests, labs
- Any special instructions

**Best Practice Example:**
Review Maury Regional Health System's Virtual Warm Handoff Training on using a virtual warm handoff during transitions to another level of care.

The training covers:

- The "why" and the benefits of using a virtual warm handoff
- Process steps for conducting virtual warm handoffs
- Tips for videoconferencing
- Maintaining telemedicine equipment
- A short video demonstration of a hospital to skilled nursing facility virtual warm handoff

**Tips:**

1. Consider the health literacy of each patient and care partner participating in the handoff.
2. Consider using technology such as tablets to engage care partners who cannot be physically present, provide a virtual introduction to the next level of care, and promote accountability between the receiving and transferring nurse.
3. Use a standard report form. Where appropriate, include scripted elements.
4. Provide instructions for using patient portals to access future appointments, test results and discharge instructions.
5. Include sending and receiving clinicians and patient care partners in the warm handoff conversation. Also, consider including a social worker or discharge planner who can provide follow-up questions and support.

| Additional Resources |
|---|
| Joint Commission: 8 Tips for High-Quality Hand-Off Graphic |
| AHRQ Handoff Pocket Guide |
| IHI Person-Centered Care Self-Assessment |
| Alliant Zone Tools |

For coaching and mentoring support in re-igniting or starting your warm handoff initiative, contact Melody.Brown@AlliantHealth.org.

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## Transitions of Care:
### MAKE TEACH-BACK AN ALWAYS EVENT!

**Teach-Back Is a Critical Element of Every Ideal Discharge**

Most patients have limited healthcare literacy and have trouble processing complex discharge instructions. Older adults have additional challenges with processing discharge information due to hearing and vision impairment. Teach-back technique provides an opportunity to offset some of these challenges.

**Getting Started:**

1. Establish a small, time-limited team or assess where your organization is in your Teach-Back journey (*are you currently using consistently across all units, all shifts, or just beginning to plan for implementation?*).
2. Identify which Teach-Back training framework is best for your organization. No-cost toolkits to consider include:

| AHRQ Teach-Back | IHI Always Use Teach-Back! |
|---|---|
| Geared towards the physician setting, but can be applied to any health care setting | Permission to use with attributions as noted on each tool. Originally created as part of the Picker Institute's Always Events Program. An Always Event refers to an aspect of the patient experience that is so important to patients and families that health care providers should reliably implement it 100% of the time |
| No login is required to access and utilize implementation resources | Requires creating a free IHI account |
| Training materials, observation tools and conviction and confidence self-assessments | Training materials, observation tools and conviction and confidence self-assessments |

3. Define your approach for considering the health literacy of older adults as you craft your implementation strategy. The AMA Foundation: Help patients understand (23-minute video) is an example of an effective tool for raising awareness of the importance of health literacy. Depending on your audience, the "House Inhaler" (44-second video available on multiple YouTube channels) can create "lightbulb moments" for staff on why Teach-Back is important.
4. Establish your Teach-Back planning and implementation team.

**Used effectively, Teach-Back can:**

- Improve adherence to a recommended plan of care.
- Improve customer satisfaction.
- Improve patients' understanding of the discharge recommendations.

**To learn more about implementation, including measuring effectiveness, contact Melody.Brown@AlliantHealth.org for coaching and mentoring support.**

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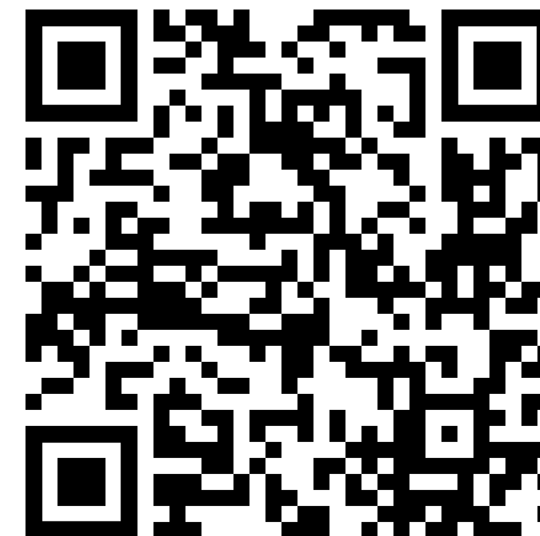
AHS Reducing Readmissions



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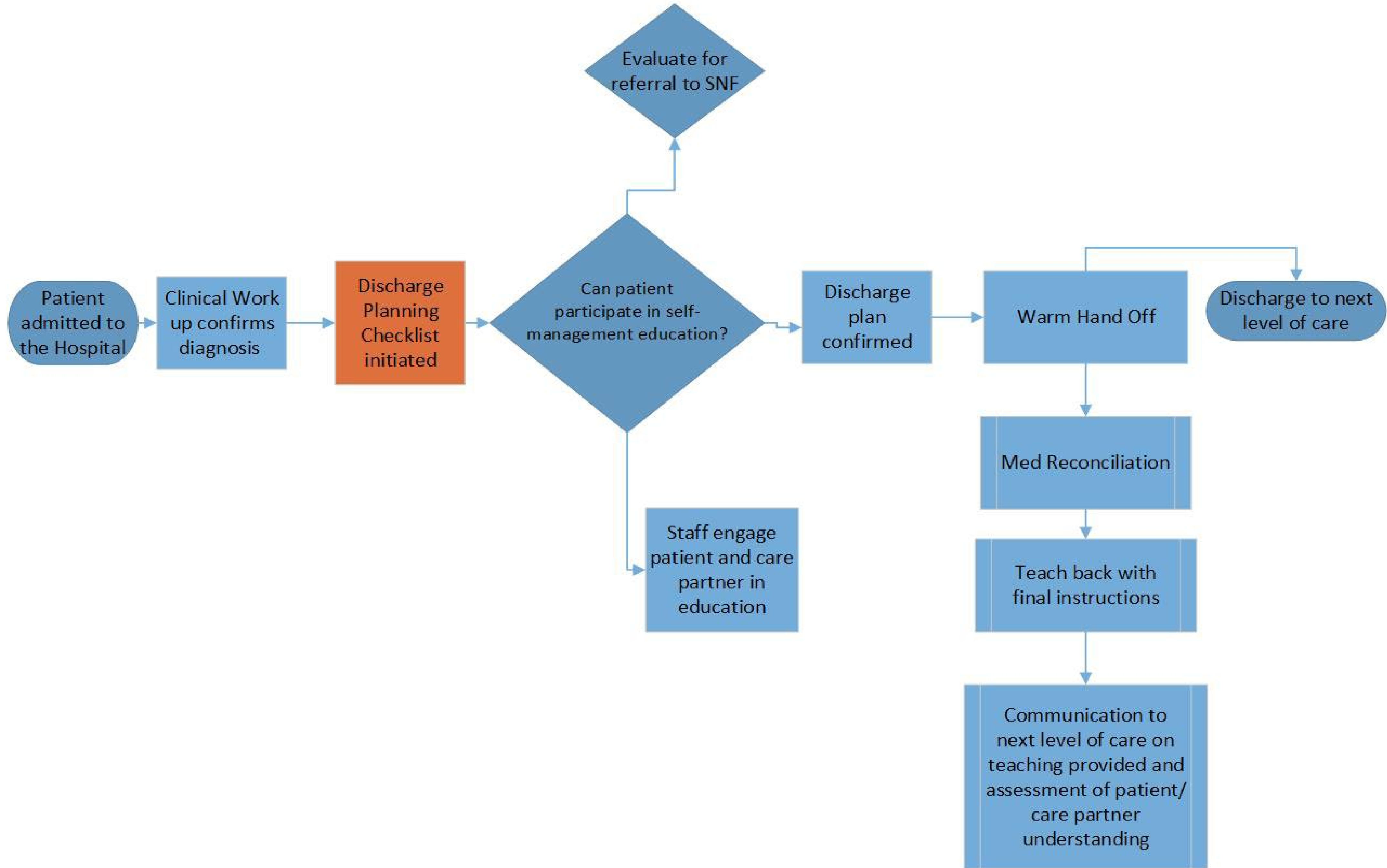
## Sample high level flow chart



# Keys to Success

- Engage patients and care partners
- Secure senior leadership support
- Implement small tests of change
- Assign key implementation roles
- Identify facility champions
- Prioritize staff training
- Periodically monitor the process once established

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