Transitions of Care:
Utilizing the AHRQ IDEAL Discharge Process

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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. 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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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.

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.

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.

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

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[Alliant Health Solutions Reducing Readmissions Resources]

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SHARE:

Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning

Research shows that when patients are engaged in their health care, it can lead to measurable improvements in safety and quality. To promote stronger engagement, Agency for Healthcare Research and Quality developed the Guide to Patient and Family Engagement in Hospital Quality and Safety, a tested, evidence-based resource to help hospitals work as partners with patients and families to improve quality and safety.

Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transition in care safe and effective. Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning highlights the key elements of engaging the patient and family in discharge planning:

Include the patient and family as full partners in the discharge planning process

Discuss with the patient and family five key areas to prevent problems at home:

- Describe what life at home will be like
- Review medications
- Highlight warning signs and problems
- Explain test results
- Make followup appointments

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay

Assess 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.

Listen to and honor the patient and family's goals, preferences, observations, and concerns.

Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook gives an overview of and rationale for the IDEAL Discharge Planning strategy and provides step-by-step guidance to help hospitals put this strategy into place and addresses common challenges.
[Microsoft Word version - 9.9 MB ; PDF version - 545.77 KB]

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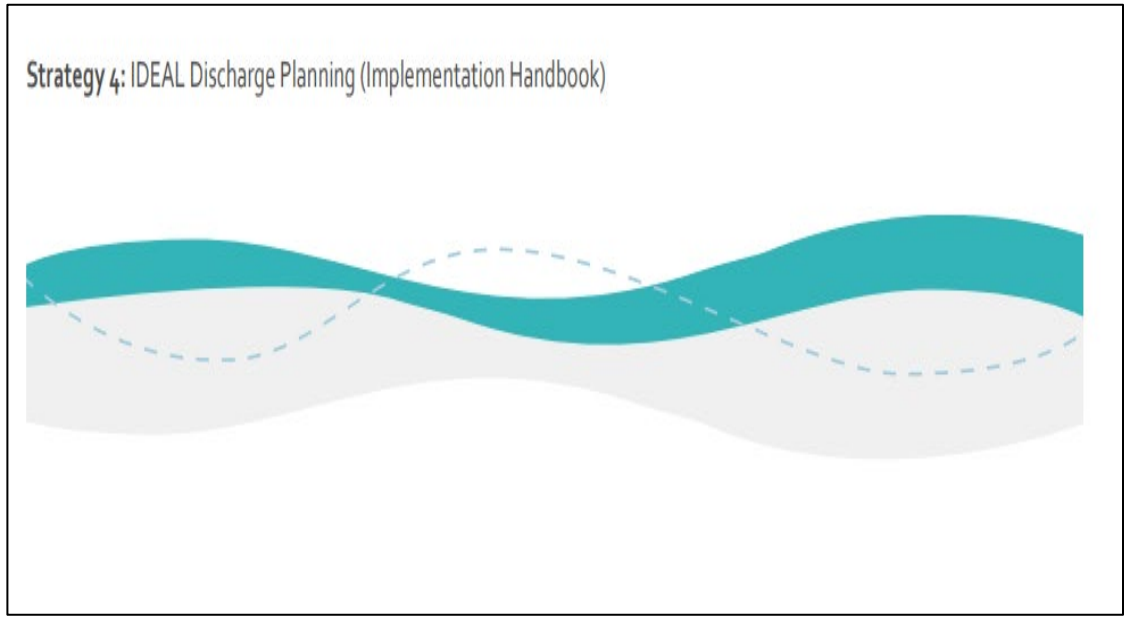
AHRQ IDEAL Discharge Planning Implementation Handbook



Care Transitions from Hospital to Home: IDEAL Discharge Planning
Implementation Handbook

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Strategy 4: IDEAL Discharge Planning (Implementation Handbook)

Table of Contents

Key Implementation Steps:

- Forming a multidisciplinary team
- Adapting the model for your facility
- Implementing and evaluating your strategy

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❑ I know about other help I need at home.

Ask:

- When I get home, what kind of help or care will I need? Should someone be with me all the time?
- Will I need home nursing care? For how long? Who pays for it?
- Will I need physical or occupational therapy for help with exercises or relearning how to do things? For how long? Who pays for it?
- Will I need help eating, bathing, or going to the bathroom? For how long?
- Will I need any equipment, such as crutches or oxygen? Where do I get it? Who pays for it? How do I use it?

❑ My doctors or nurses answered all of my questions.

You may have other questions or concerns that are not in this checklist. Please ask us your questions. Make sure you have your answers **before** you leave.

Tips for Going Home

Patients and families at [insert hospital name] wrote these tips to help you get ready to go home: [Use patient and family advisors to tailor this list to your hospital.]

- Write down what your doctors and nurses say.
- Ask questions until you understand and get the answers you need.
- Make lists of what needs to be done, who can do it, and who can help.
- Talk with someone who has been in your situation to help you prepare and know what to expect.
- Talk to other people in the hospital, such as social workers, chaplains, and other patients, about your care or other help you may need.

Going Home Too Soon?

If you feel that you are going home before you are ready, call [insert name] at [phone number].

Be Prepared To Go Home Checklist

Before you leave the hospital, we want to make sure you feel ready to go home. During your hospital stay, your doctors and nurses will make sure to answer your questions and talk to you about your concerns. We want you to have all the information you need.

Use this checklist to see what information you still need from us as you or your family member prepare to go home. If you cannot check a box, use the questions listed to ask your doctor or nurse about the information you need.

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❑ I feel confident that I or someone close to me can take care of me at home.

Ask:

- How do I take care of any wounds, cuts, or incisions? Can you show me how to do this?
- What foods or drinks should I avoid? For how long?
- Are there any activities I should not do like driving, sex, heavy lifting, or climbing stairs? For how long?
- What exercises are good for me? When and how often should I do them?
- What do I need to do to make my home safer?

❑ My family or someone close to me knows I am coming home and knows the next steps in my care.

Ask:

- Will I need help when I get home? If so, who will help me? What do they need to do to get ready?
- What should I do if there is no one at home who can help me?

❑ I know what my medicines are and how to take them.

Ask:

- What medicine(s) do I need to take when I leave the hospital? Do I take the same medicines that I took before I went into the hospital?
- What is the name of this medicine? Is this the generic or brand name?
- Why do I take this medicine?
- When and how do I take this medicine?
- How much do I take?
- What does this medicine look like?
- What are potential side effects of this medicine? What problems do I need to look out for?
- Will this medicine interfere with other medicines, foods, vitamins, or other herbal supplements I take?
- Where and how do I get this medicine?
- What medicines can I take for pain? Upset stomach? Headaches? Allergies?

❑ I know what problems to look for and who to call if I have problems at home.

Ask:

- What problems do I need to watch for when I get home? If I have problems, how do I know when I should call?
- Who do I call if I have questions or problems when I get home?
- If I have questions about my care after I leave the hospital, should

  call_____

  at _____

❑ I know when my followup appointments are and how to get there.

Ask:

- What appointments do I need after I leave the hospital? Can the hospital help me make these appointments?
- Am I waiting on results of any tests? When should I get the results?
- Are there tests I need after I leave the hospital?

I AM CONCERNED ABOUT…	YES	NO	COMMENTS
Follow-Up Medical Care			
Having all the information I need when I leave			
Follow-up care after leaving			
Scheduling follow-up appointments and/or tests			
Who to call with questions or concerns			
How I will get to my doctor's follow-up appointment			
Whether I will need home nursing, therapists, nutritionists			
The type of medical equipment I will need (e.g., walker, crutches, insulin pump, oxygen)			
Managing my wound care			
Paying for the care I need			
Medications			
Which medications I should take at home			
When to take my medications			
Taking my medications as prescribed (e.g., swallowing)			
Understanding the side effects of my medications			
Paying for my medications			
Getting my medications from the pharmacy			
Activities of Daily Living			
Getting help with personal care (e.g., bathing, dressing)			
Cooking meals			
Getting help with grocery shopping			
Using medical equipment, changing a bandage, or giving an injection			
Care Partner			
How my family or other caregivers will help me when I am at home			
How my family or other caregivers will manage my illness			
Losing contact with friends and family, and feeling isolated or left behind			
Culture			
Whether I will be able to keep my core beliefs and values despite my illness			

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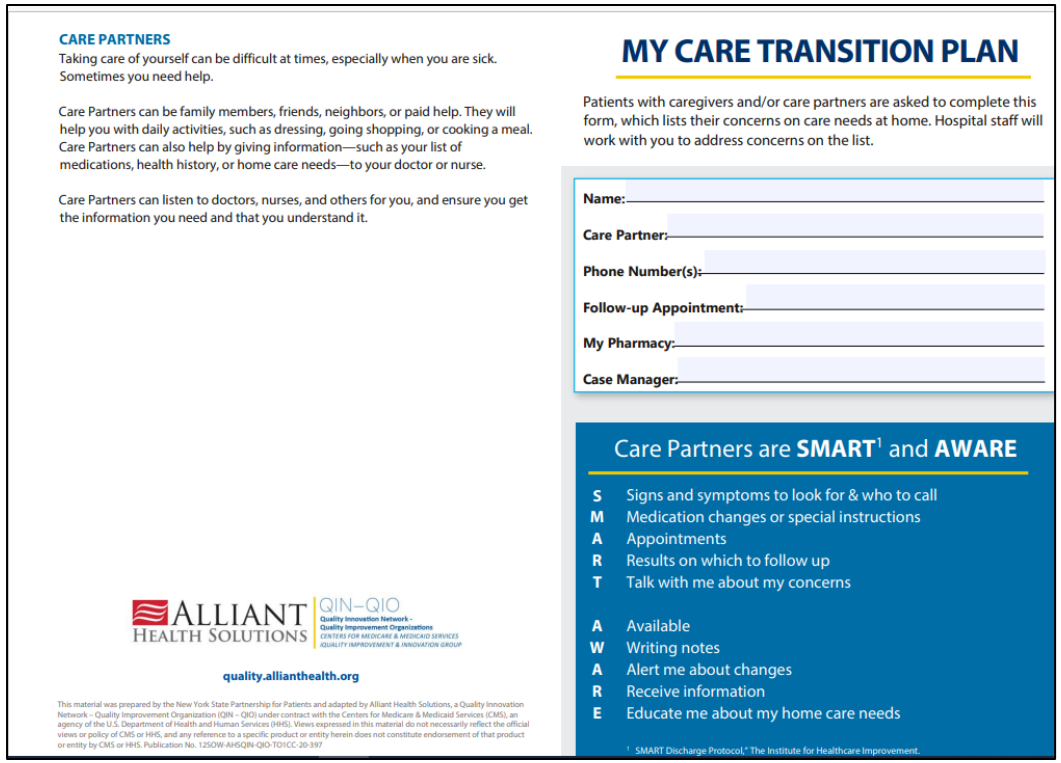

CARE PARTNERS

Taking care of yourself can be difficult at times, especially when you are sick. Sometimes you need help.

Care Partners can be family members, friends, neighbors, or paid help. They will help you with daily activities, such as dressing, going shopping, or cooking a meal. Care Partners can also help by giving information—such as your list of medications, health history, or home care needs—to your doctor or nurse.

Care Partners can listen to doctors, nurses, and others for you, and ensure you get the information you need and that you understand it.

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MY CARE TRANSITION PLAN

Patients with caregivers and/or care partners are asked to complete this form, which lists their concerns on care needs at home. Hospital staff will work with you to address concerns on the list.

Name:_____
Care Partner:_____
Phone Number(s):_____
Follow-up Appointment:_____
My Pharmacy:_____
Case Manager:_____

Care Partners are **SMART**[1] and **AWARE**

- **S** Signs and symptoms to look for & who to call
- **M** Medication changes or special instructions
- **A** Appointments
- **R** Results on which to follow up
- **T** Talk with me about my concerns

- **A** Available
- **W** Writing notes
- **A** Alert me about changes
- **R** Receive information
- **E** Educate me about my home care needs

[1] SMART Discharge Protocol," The Institute for Healthcare Improvement.

[Alliant Health Solutions My Care Transitions Plan]

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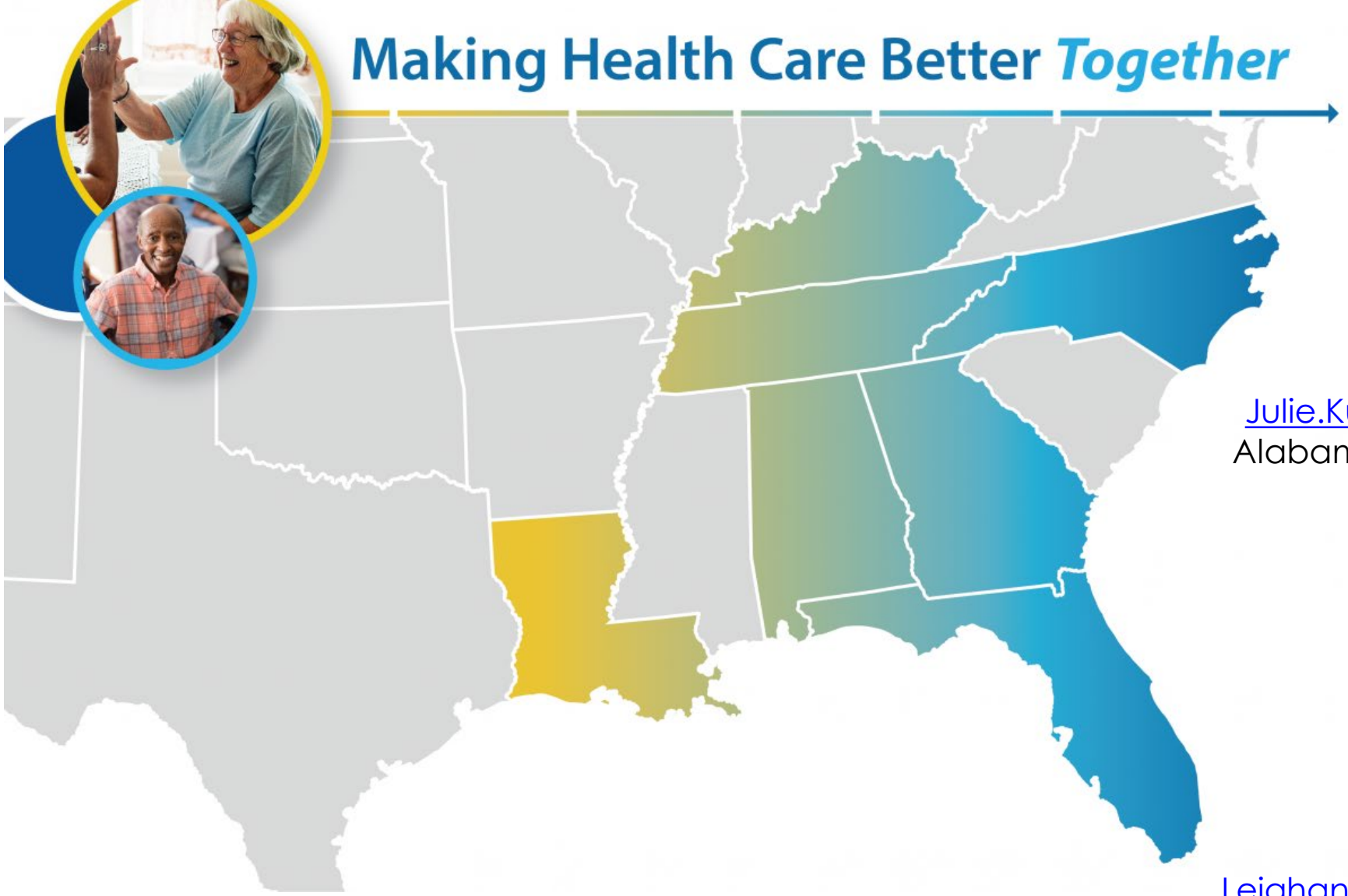

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