



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



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## Introduction

*The Guide to Patient and Family Engagement in Hospital Quality and Safety* is a resource to help hospitals develop effective partnerships with patients and family members with the ultimate goal of improving multiple aspects of hospital 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.

This handbook gives an overview of and rationale for the IDEAL Discharge Planning strategy. It also provides step-by-step guidance to help you put this strategy into place at your hospital and addresses common challenges. Throughout this handbook, we include examples and real-world experiences from Advocate Trinity Hospital in Chicago, IL, which implemented IDEAL Discharge Planning as part of a year-long pilot project.

## Overview of the IDEAL Discharge Planning strategy

The goal of the IDEAL Discharge Planning strategy is to engage patients and family members in the transition from hospital to home, with the goal of reducing adverse events and preventable readmissions. The IDEAL Discharge Strategy can be used on its own or in conjunction with other initiatives, including RED (Re-engineering Discharge), the Care Transitions program, and BOOSTing (Better Outcomes for Older Adults Through Safe Transitions) Care Transitions.

### Interested in improving transitions from hospital to home?

Read this handbook for detailed instructions on how to adapt and implement the **IDEAL Discharge Planning** strategy at your hospital.

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\* The *Guide* was developed for the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality by a collaboration of partners with experience in and commitment to patient and family engagement, hospital quality, and safety. Led by the American Institutes for Research, the team included the Institute for Patient and Family-Centered Care, Consumers Advancing Patient Safety, the Joint Commission, and the Health Research and Educational Trust. Other organizations contributing to the project included Planetree, the Maryland Patient Safety Center, Aurora Health Care, and Emory University Hospital.

The IDEAL Discharge Planning strategy highlights the key elements of engaging the patient and family in 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 **at every opportunity** 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 and family's goals, preferences, observations, and concerns.

Components of each IDEAL element are described in more detail on the following pages.



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

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event but is a process that takes place throughout the hospital stay.
- Identify which family members or friends will provide care at home and include them in conversations.

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

1. **Describe what life at home will be like.** Include home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
2. **Review medications.** Use a reconciled medication list to discuss the purpose of each medicine, how much to take, how to take it, and potential side effects.
3. **Highlight warning signs and problems.** Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.
4. **Explain test results.** Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should hear about results and identify who they should call if they have not heard the results by that date.
5. **Make followup appointments.** Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.



**E**ducate 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.

Getting all the information about a condition and next steps on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay, not a one-time event. During the hospital stay, you can:

- Elicit patient and family goals at admission and note progress toward those goals each day
- Involve the patient and family in nurse bedside shift report or bedside rounds
- Share a written list of medicines every morning
- Go over medicines at each administration: What it is for, how to take it, and possible side effects
- Encourage the patient and family to take part in care practices to support their competence and confidence in caregiving at home

**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.

- Provide information to the patient in small chunks and repeat key pieces of information throughout the hospital stay
- Ask the patient and family to repeat what you said back to you in their own words to be sure that you explained things well

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

- Invite the patient and family to use the white board in the room to write questions or concerns
- Ask open-ended questions to elicit questions and concerns
- Use the Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to make sure the patient and family feel prepared to go home
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers

## What are the IDEAL Discharge Planning tools?

This section provides an overview of the tools included in this strategy. The set of tools included in this *Guide* are for discharges to home only, with or without home- and community-based services, such as home health care.

	Use this tool to	Description and formatting
<b>Tool 1</b>		
<b>IDEAL Discharge Planning Overview, Process, and Checklist</b>	Inform clinicians about the new discharge planning process and keep track of when tasks are accomplished	<ul style="list-style-type: none"> <li>Used by clinicians, this handout gives an overview of the IDEAL Discharge Planning process and includes a checklist that could be completed for each patient.</li> <li>Format: 2-page overview, 2-page process steps, 2-page checklist</li> </ul>
<b>Tools 2a and 2b</b>		
<b>Be Prepared to Go Home Checklist and Booklet</b>	Identify and discuss the patient and family's questions and concerns about going home	<ul style="list-style-type: none"> <li>Given to patients soon after admission, the checklist highlights what the patient and family need to know before leaving the hospital and gives examples of questions they can ask. The booklet companion piece contains the checklist plus additional space for writing information.</li> <li>Format: Tri-fold checklist, 14-page booklet. The electronic version of the tri-fold checklist provides information about how to fold the brochure by indicating the front and back covers.</li> </ul>
<b>Tool 3</b>		
<b>Improving Discharge Outcomes with Patients and Families</b>	Inform physicians of the IDEAL Discharge Planning process	<ul style="list-style-type: none"> <li>Given to physicians, this handout describes the new discharge planning process. A verbal description should also accompany the distribution of the handout at a staff meeting or other venue.</li> <li>Format: 1-page handout</li> </ul>
<b>Tool 4</b>		
<b>Care Transitions from Hospital to Home: IDEAL Discharge Planning Training</b>	Prepare clinicians and hospital staff to support the efforts of patient and family engagement related to discharge planning	<ul style="list-style-type: none"> <li>This training is for any staff involved in the discharge process: Physicians, nurses, discharge planners, social workers, and pharmacists.</li> <li>Format: PowerPoint presentation and talking points</li> </ul>

## What is the IDEAL Discharge Planning process?

The IDEAL Discharge Planning strategy focuses on engaging the patient and family in the discharge process from the hospital to home. You can incorporate elements of the IDEAL Discharge Planning process into your current discharge process. This process incorporates the IDEAL elements from admission to discharge and includes at least one meeting between the patient, family, and discharge planner to specifically address the patient's and family's questions and concerns.

What to do?	Who does it?
<b>At initial nursing assessment</b>	
<ul style="list-style-type: none"> <li>Identify the caregiver who will be at home with the patient</li> </ul>	<p><b>Bedside nurse</b></p>
<ul style="list-style-type: none"> <li>Let the patient and family know that they can use the white board in the room to write questions or concerns</li> </ul>	<p><b>Bedside nurse</b></p>
<ul style="list-style-type: none"> <li>Elicit the patient and family's goals for the hospital stay</li> </ul>	<p><b>Bedside nurse</b></p>
<ul style="list-style-type: none"> <li>Inform the patient and family about steps toward discharge</li> </ul>	<p><b>Bedside nurse</b></p>
<b>Daily activities</b>	
<ul style="list-style-type: none"> <li>Educate the patient and family about the patient's condition at every opportunity and use teach back</li> </ul>	<p><b>All clinical staff</b></p>
<ul style="list-style-type: none"> <li>Explain medicines to the patient and family and use teach back</li> </ul>	<p><b>All clinical staff</b></p>
<ul style="list-style-type: none"> <li>Discuss progress toward goals</li> </ul>	<p><b>All clinical staff</b></p>
<ul style="list-style-type: none"> <li>Involve the patient and family in care practices</li> </ul>	<p><b>All clinical staff</b></p>
<b>Prior to discharge planning meeting</b>	
(1 to 2 days before discharge planning meeting; for short stays, this may occur at admission)	
<ul style="list-style-type: none"> <li>Give Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to the patient and family</li> </ul>	<p><b>Hospital identifies one person: Nurse, patient advocate, or discharge planner</b></p>
<ul style="list-style-type: none"> <li>Schedule discharge planning meeting with the patient, family, and hospital staff</li> </ul>	<p><b>Hospital identifies one person: Nurse, patient advocate, or discharge planner</b></p>



What to do?	Who does it?
<p><b>Discharge planning meeting</b> (1 to 2 days before discharge or earlier for more extended stays in the hospital)</p>	
<ul style="list-style-type: none"> <li>Use the Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) as a starting point for discussion on questions, needs, and concerns about going home</li> </ul>	<p><b>Hospital identifies one person or a combination: Nurse, physician, patient advocate, discharge planner</b></p>
<ul style="list-style-type: none"> <li>Offer to make followup appointment(s) and ask if the patient has a preferred day and time and if they can get to the appointment</li> </ul>	<p><b>Hospital identifies one person or a combination: Nurse, patient advocate, discharge planner</b></p>
<p><b>Day of discharge</b></p>	
<ul style="list-style-type: none"> <li>Review a reconciled medication list with the patient and family</li> </ul>	<p><b>Hospital identifies one person: Nurse, physician, or pharmacist</b></p>
<ul style="list-style-type: none"> <li>Give the patient and family their followup appointments, if applicable, and include provider name, time, and location of appointments</li> </ul>	<p><b>Staff who scheduled appointments</b></p>
<ul style="list-style-type: none"> <li>Give the patient and family the name, position, and phone number of the person to contact if there is a problem after discharge</li> </ul>	<p><b>Hospital identifies one person: Nurse, patient advocate, or discharge planner</b></p>

### What are the resources needed?

Resources needed for the IDEAL Discharge Planning strategy will vary from hospital to hospital depending on the size and scope of what you are setting out to accomplish.

- Staffing.** Staff resources involved in this strategy include time for: The point person and multidisciplinary team to identify needs and adapt the strategy; the trainers to prepare and conduct the training; staff champions (registered nurse champion, physician, discharge planner, and so forth) for overall support of process changes; scheduling and conducting discharge planning meeting; scheduling patient followup appointments; and implementation team members who monitor and provide feedback to staff for at least 2 to 3 weeks. Staff carry out other processes as part of their regular duties.
- Costs.** Material costs include printing of the patient and family checklist and booklet (Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet) and printing of the clinician checklist (Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist).

## Rationale for the IDEAL Discharge Planning Strategy

Patient and family engagement creates an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care. Patient and family engagement encompasses **behaviors** by patients, family members, clinicians, and hospital staff, as well as the **organizational policies and procedures** that support these behaviors.

Discharge from a hospital can be a complex process: It is not a one-time event, and no single act will make it work better. Discharge involves care coordination among hospital staff; between hospital staff, the patient, and family; between hospital staff and community providers; and between the patient, family, and community providers.

For discharge to be most effective, communication between clinicians, the patient, and family needs to happen throughout the hospital stay. Education and learning is a two-way path:

- The patient and family need to learn from clinicians about the condition and next steps.
- Clinicians need to learn from the patient and family about their home situation (both what help and support they can count on and the barriers they may face in taking care of themselves) and to learn what questions they have after they get home. Clinicians also need to make sure that patients and family members *really* understand the next steps in their care.

### What is the evidence for improving discharge planning?

Nearly 20 percent of patients experience an adverse event within 3 weeks of discharge, according to one study.<sup>1</sup> Of these adverse events, three-quarters could have been prevented or ameliorated. Common complications post-discharge include adverse drug events, hospital-acquired infections, and procedural complications.

In another study, nearly 20 percent of Medicare patients were rehospitalized within 30 days after discharge. Of the readmitted patients, half the patients had no claim filed for a visit with a physician during the 30 days following the discharge, and about 70 percent of surgical patients were rehospitalized with a medical problem. The authors estimate that the cost of these unplanned hospitalizations in 2004 was \$17.4 billion.<sup>2</sup>



Nurses at Advocate Trinity Hospital noted that IDEAL Discharge Planning made them more aware of their patients' needs. One nurse described her reluctance to "dig into people's business" but noted that going through the IDEAL Discharge Planning checklist (Tool 1) provided her with important information about her patients and their home situations.

Rehospitalization has become a focus of attention for hospitals, purchasers, hospital quality organizations, and others because of increased focus on the problem of readmissions. To highlight the importance of reducing readmissions, Section 3025 of the Affordable Care Act allowed the Centers for Medicare & Medicaid Services (CMS), beginning in 2012, to penalize hospitals with higher-than-average readmissions rates for Medicare patient who had been treated for at least one of three conditions (heart failure, heart attack, or pneumonia) within the last 30 days.

The Commonwealth Fund developed case studies of four hospitals with 30-day readmission rates in the lowest 3 percent among all U.S. hospitals for at least two of three conditions (heart failure, heart attack, and pneumonia) reported by CMS from the fourth quarter of 2007 through the third quarter of 2008. These case studies identified the following best practices, among others:<sup>3</sup>

- **A focus on improving clinical quality and patient care** with the belief that reductions in readmissions will naturally occur as a result of these improvement efforts.
- **Attention to discharge planning from the first day of patients' stay**, typically within 8 hours of admission. This includes staff assessment of patients' risk factors, needs, available resources, knowledge of disease, and family support.
- **Care coordination after discharge.** Two hospitals scheduled followup appointments for most of their patients prior to discharge. Because of limited resources, the two other hospitals made followup appointments on an ad hoc basis for the neediest patients. All hospitals coordinated with home health agencies and connected patients to community resources.
- **Empowering patients through educational activities throughout the stay** to help patients understand their conditions; manage their diet, activities, medications, and care regimens; and know when to seek care.

The IDEAL Discharge Planning strategy includes tools to help hospitals incorporate these best practices.

## What are the key challenges related to discharge?

Several important challenges have been identified in providing high-quality care as patients leave the hospital:



Advocate Trinity Hospital observed positive outcomes as a result of implementing IDEAL Discharge Planning, including improved CAHPS® Hospital Survey scores. For more information, see the case study at the end of this handbook.



### Helpful Links

The goal of the Agency for Healthcare Research and Quality's MATCH toolkit is to decrease the number of patients receiving potentially conflicting medications when they leave the hospital or transfer to different care settings. The toolkit provides clear instructions on creating flowcharts to avoid gaps in reconciling medication; identifying roles and responsibilities for medication reconciliation; collecting data to measure progress; and assisting in the design and implementation of a single, shared medication history called the "One Source of Truth." MATCH is designed to assist clinicians in all types of health care organizations—including hospitals and outpatient settings—and is compatible with both paper-based and electronic medical records. Available at: <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/index.html>

- **Discontinuity between inpatient and outpatient providers.** Hospital discharge summaries often fail to reach outpatient providers, and when they do, they neglect to provide important administrative and medical information. In one study, only 34 percent of primary care physicians received the discharge information needed to continue managing their patients within 48 hours of discharge.<sup>7</sup> Also, patients have multiple providers, making continuity of care more difficult between inpatient and outpatient settings.<sup>4</sup>
- **Changes or discrepancies in medication lists before and after a hospital stay.** To make sure there is an accurate medication list at hospital discharge, hospital providers need to take a complete and accurate medication history at the time of admission, keep track of changes to medications administered throughout the hospital stay, and reconcile medication lists at discharge. Patients prescribed high-risk medications or complex medication regimens may be at higher risk of adverse drug events.<sup>4,6,8</sup>
- **Inadequate preparation for discharge.** Quality of discharge teaching is the strongest predictor of discharge readiness. Patients may not be properly informed about food choices, medication side effects, danger signs, and when to resume activities. Also, studies have shown a disconnect between the information that patients and families believe they need to know and what providers think patients need to know.<sup>4,5,6</sup>
- **Disconnect between provider information-giving and patient understanding.** Studies have demonstrated that providers may not relay information to patients in a way they can understand. Key instructions at discharge should be given in plain language, use both verbal and audiovisual instruction, be repeated by multiple providers (e.g., physician, nurse, and pharmacist), and be confirmed using a teach-back method where patients are asked to repeat back what they understood about their discharge instructions in their own words.<sup>4</sup>
- **Burden of care assumed by patients and families after discharge.** Patients are responsible for administering new medications, tracking symptoms, participating in physical therapy, and following up with their outpatient physician. Many patients do not have sufficient social and family support to perform these activities effectively. Also, patients may feel overwhelmed and unprepared to take an active role in their health care without adequate information, and in some cases, coaching.<sup>4,5</sup>



### Helpful Links

For more information on other approaches to improving discharge, see the following resources:

- **Care Transitions Program®**, available at: <http://www.caretransitions.org/>
- **RED (Re-Engineered Discharge)**, available at: <http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html>
- **BOOSTing Care Transitions Project**, available at: [http://www.hospitalmedicine.org/ResourceRoom/Redesign/RR\\_CareTransitions/CT\\_Home.cfm](http://www.hospitalmedicine.org/ResourceRoom/Redesign/RR_CareTransitions/CT_Home.cfm)
- **Transforming Care at the Bedside**, available at: <http://www.ihl.org/knowledge/Pages/Tools/TCABHowToGuideTransitionHomeforHF.aspx>



The IDEAL Discharge Planning materials in the *Guide* build on these important initiatives, focusing on those elements intended to engage the patient and family in their care. The **IDEAL Discharge Planning** strategy and tools can stand on their own or be used along with these successful initiatives.

## How to prevent adverse events after discharge

Many of the challenges described above can be attributed to problems in discharge planning. **Discharge planning** is the process of identifying and preparing for a patient's anticipated health care needs after they leave the hospital.<sup>9</sup> Hospital staff cannot plan discharge in isolation from the patient and family.

Comprehensive discharge planning involving the patient and family contributes to positive patient outcomes, such as reductions in unplanned readmissions and increases in patient and caregiver satisfaction with the health care experience.<sup>10,11</sup> However, it is often difficult for hospitals to conduct comprehensive discharge planning given the shortened length of stays for most hospital admissions. That is why it is critical to involve and educate the patient and family throughout the hospital stay.

Ensuring safe transitions from hospital to home requires a systematic approach that includes the patient and family in the discharge process. At this time, no consensus exists on the single best method to prevent adverse events after discharge. However, there is promising evidence related to specific interventions. For example, various medication reconciliation approaches have shown promise in improving clinical outcomes, although more research is needed to verify these findings. Other promising interventions include using discharge checklists to standardize the discharge process and making structured post-discharge phone calls to patients. Similarly, evidence is mounting for interventions that incorporate structured discharge communication. In this type of approach, specially trained staff meet with patients before (and sometimes after) discharge to reconcile medications, instruct patients and caregivers in self-care methods, prepare patient-centered discharge instructions, and facilitate communication with outpatient physicians.

The Care Transitions Program, work on transitional care interventions with advanced practice nurses, and RED (Re-Engineered Discharge) use variations of this method, and all successfully reduced readmissions and emergency department visits after discharge.<sup>12-14</sup> Other interventions aimed at transitions from hospital to home show similar promise. The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions project uses a combination of assessment and communication strategies for improving discharge outcomes for older adults. Also, Transforming Care at the Bedside, a national program from the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement, developed the How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure. This guide integrates what hospitals that participated in Transforming Care at the Bedside learned as they strove to improve the quality of care for patients discharged from the hospital to home or to another health care facility.

## How does the IDEAL Discharge Planning strategy improve the discharge process?

The IDEAL Discharge Planning strategy focuses on engaging the patient and family in the discharge process. This approach involves working **with** patients and families rather than only doing something to or for patients and families.

## How does engaging the patient and family differ from a typical discharge process?

<b>Time point</b>	<b>In the typical discharge process, hospital staff:</b>	<b>In a discharge process that engages the patient and family, hospital staff also:</b>
<b>At admission</b>	<ul style="list-style-type: none"> <li>• Transcribe admission orders to the hospital record and follow up with community providers for missing information or records</li> <li>• Reconcile the medication list</li> </ul>	<ul style="list-style-type: none"> <li>• Identify caregivers who will be at home with the patient</li> <li>• Elicit the patient’s and family’s goals for the hospital stay</li> <li>• Inform the patient and family about steps toward discharge</li> <li>• Let the patient and family know they can use the white board to write questions or concerns</li> </ul>
<b>Daily during hospital stay</b>	<ul style="list-style-type: none"> <li>• Manage the patient’s condition</li> <li>• Assign a case manager or discharge planner to the patient</li> </ul>	<ul style="list-style-type: none"> <li>• Educate the patient and family about the patient’s condition at every opportunity using teach back</li> <li>• Explain medications to the patient and family using teach back</li> <li>• Discuss progress toward goals and discharge</li> <li>• Involve the patient and family in care practices to prepare for home care</li> </ul>
<b>Prior to discharge</b>	<ul style="list-style-type: none"> <li>• Coordinate home-based care and special equipment needs</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare the patient and family for transition to home</li> <li>• Schedule the discharge planning meeting with the patient and family</li> <li>• Offer to make followup appointment for the patient</li> </ul>
<b>On day of discharge</b>	<ul style="list-style-type: none"> <li>• Write discharge orders and dictate the discharge summary (physician only)</li> <li>• Reconcile the medication list</li> <li>• Give written discharge instructions to the patient and family</li> </ul>	<ul style="list-style-type: none"> <li>• Use teach back to assess how well providers have explained diagnosis, condition, and discharge instructions to the patient and family</li> <li>• Review the reconciled medication list with the patient and family</li> <li>• Write down the followup appointment times for the patient and family</li> <li>• Write the name, position, and phone of the hospital person to contact if there is a problem after discharge</li> </ul>

The tools in this strategy support discharge planning among the patient, family, clinicians, and hospital staff in several ways. They:

- Identify ways clinicians and hospital staff can include the patient and family as full partners in the discharge planning process
- Provide an opportunity for the patient and family to think about the discharge throughout the hospital stay
- Train clinicians and hospital staff on opportunities for educating the patient and family and ways to confirm understanding
- Provide a structured setting in which patients and families can discuss their concerns and get their questions answered, prior to the day of discharge
- Make sure that the patient has a followup appointment prior to leaving the hospital
- Ensure that patients know who to call if they are having problems

Also, the Joint Commission suggests that hospitals meet the following four goals in a discharge process:

1. Address patient communication needs during discharge and transfer
2. Engage patients and families in discharge and transfer planning and instruction
3. Provide discharge instruction that meets patient needs
4. Identify followup providers that can meet unique patient needs

The IDEAL Discharge Planning strategy helps to meet these goals.

## Implementing the IDEAL Discharge Planning Strategy

The IDEAL Discharge Planning strategy is designed to be flexible and adaptable to each hospital's environment and culture. As such, this section provides choices and questions for hospital leaders about how to implement this strategy. It may be helpful to implement this strategy initially on a small scale (e.g., a single unit). Identify lessons learned from the single-unit pilot implementation, refine your approach, and then spread to more units. In this way, you can build on your successes as a pathway to broader dissemination and wider scale change.

### Step 1: Form a multidisciplinary team to identify areas of improvement

As with any new activity or quality improvement effort, planning and identifying areas of improvement are important parts of the process. Below are some key considerations as you get started implementing the IDEAL Discharge Planning strategy.

#### Guide Resources



For more information on working with patient and family advisors, see

**Strategy 1, Implementation Handbook: Working With Patients and Family Advisors**

#### **Engage patients and families and unit staff in the process: Establish a multidisciplinary team**

This team should include hospital leaders, physicians, nurses, other key clinical and management staff, and patient and family representatives. Throughout the process of implementing the IDEAL Discharge Planning strategy, patient and family advisors can:

- 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 hospital (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





### Guide Resources

For more information about family presence policies, see

**How to Use the Guide to Patient and Family Engagement in Information to Help Hospitals Get Started.**

### **Assess family visitation policies**

Family members cannot be part of the health care team if they are not present. It is important that the patient can define who is included the family and that these members of the health care team are encouraged and supported.

In conjunction with implementing the IDEAL Discharge Planning strategy, certified nursing assistants at Advocate Trinity Hospital drafted an open family presence policy to replace their previous visiting hours. This policy was implemented to recognize the importance of family members being present throughout a patient's hospital stay. The open family presence policy at Advocate Trinity hospital outlined guidelines for visitors with the goal of ensuring the well-being and safety of all patients.

### **Assess current views on the discharge process, including how patients and family members are engaged**

Use the multidisciplinary team to review discharge planning from all perspectives: Clinicians, hospital staff, patients, and families. Review formal survey measures and readmission rates and talk to people about their thoughts on discharge planning. The team can identify:

- **Current steps in the discharge planning process.** Which hospital staff are involved in the process? How do they coordinate their interactions with the patient and family? How satisfied are the clinicians, hospital staff, patients, and family with the process?
- **Strengths related to discharge planning.** What is done well? How are patients and families engaged? What works well to make sure the patient and family understand all of the next steps in their care? What factors seem to support patient and family engagement in discharge planning? How can we replicate them?
- **Areas for improvement and possible challenges to implementing the IDEAL Discharge Planning process and tools.** What parts of the discharge process could be improved? What are the challenges that need to be addressed from the patient, family, clinician, and hospital staff perspectives? When identifying areas for improvement, the team may want to informally introduce the concepts of the IDEAL Discharge Planning strategy and listen to concerns from clinicians and hospital staff related to implementation. In adapting the materials for your hospital, make sure to address those specific concerns.

### **Recognize challenges in changing staff behavior**

Improving the discharge planning process may require new behaviors from each member of the health care team: The patient, family, clinicians, and hospital staff. Keep in mind that taking on new behaviors will be challenging.

Some examples of challenges related to engaging patients and families in discharge planning and ways to overcome those challenges are:

- **Clinicians and hospital staff may feel that they already engage the patient and family in discharge planning or may not know how to incorporate new communication approaches into their care.** Although many clinicians recognize the importance of communication, they tend to be overly positive in their perceptions of how effectively they communicate.<sup>15</sup> Even when providers see the need for better communication, such as with the use of teach back, it may be difficult to operationalize those skills in practice.<sup>16</sup> Use the table on page 11 to highlight how the IDEAL Discharge Planning process differs from what your hospital is current doing.
- **Staff have inadequate time to prepare the patient and family for discharge.** Occasionally, the physician's discharge orders may come as a surprise to discharge planning staff or bedside nurses. Similarly, hospital staff may feel pressure to rapidly make a bed available for another patient. Because of limited time, hospital staff may not feel they are able to engage the patient and family in the discharge planning process, reducing the effectiveness of some discharges. Recognize that discharge planning is not a one-time event but a process throughout the hospital stay. Taking steps throughout the hospital stay to educate patients and families about their condition, progress toward goals, and next steps in their care will help lessen the surprise on the day of discharge.
- **Negotiating interactions with family members can be sensitive.** Families are complicated, and it may be difficult for clinicians and hospital staff to know which family members should be involved in discharge planning and how to interact with those family members. As part of the initial nursing assessment, it is important for nurses to ask patients which family or friends they would like to participate and who will be involved in their care at home.

- **Staff may fear change.** Some clinicians or hospital staff may fear losing control of the discharge planning process or may not feel confident in engaging the patient and family in discharge planning. Often, if consistent use of the IDEAL Discharge Planning is not monitored, clinicians or hospital staff may revert back to the old way. It is important to let clinicians and hospital staff know that the IDEAL Discharge Planning is not optional. Acknowledge that change is difficult but stress the importance of engaging the patient and family in the discharge planning process.

It is important for your hospital to identify the challenges that are most likely to arise in your environment and to identify ways to overcome these challenges.

### **Set aims to improve discharge planning**

Once you have a strong understanding of the existing family presence policies and discharge planning challenges you can identify what needs to be improved and ways to measure that improvement. Any quality improvement initiative requires setting aims. The aim should be time specific, measurable, and define who will be affected.

For example, an aim related to implementing the IDEAL Discharge Planning strategy could be “to have five units implementing the IDEAL Discharge Planning tools within 6 months.” Other aims could be “95 percent of patients will have a discharge planning meeting to discuss concerns within 6 months” or “reduce the number of preventable 30-day readmissions by 10 percent by the end of the fourth quarter.”

As another example, hospitals may want to improve patients’ experience of care as measured by the CAHPS® Hospital Survey. CAHPS Hospital Survey questions related to discharge include:

- Q19: During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- Q20: During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

If a hospital wants to improve its CAHPS Hospital Survey scores related to discharge, an aim might be “to improve scores on CAHPS Hospital Survey Questions 19 and 20 by 5 percent within 1 year.”

#### **Helpful Link**



For more information on setting aims and identifying measures, see the Institute for Healthcare Improvement’s Web site on improvement methods, available at:

[http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/Methods/HowToImprove/.](http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/Methods/HowToImprove/)

## Guide Resources

### **Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist**

informs all clinicians about the new discharge planning process and keeps track of when tasks are accomplished.

### **Tool 2a and 2b: Be Prepared to Go Home Checklist and Booklet**

are companion pieces that help the patient and family identify questions and concerns about going home.

### **Tool 3: Improving Discharge Outcomes With Patients and Families**

informs physicians of the IDEAL Discharge Planning 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.

## Step 2: Decide on how to implement the IDEAL Discharge Planning strategy

Once the team has set specific aims for improvement, it may be helpful to identify a point person as the primary person staff would contact with any kind of question. This person may not have the answers to all questions but can facilitate the process of getting answers. This way, people are clear about whom to go to, and that person will hear all the questions and concerns.

The point person can then coordinate with the multidisciplinary team to decide how to use and adapt each of the tools in this strategy.

### **Decide on how to adapt the IDEAL Discharge Planning process for your hospital**

The IDEAL Discharge Planning strategy includes five tools. Answering the following questions will help you decide how to use and adapt the tools in this strategy at your hospital:

- **Decide on how to use and adapt the IDEAL Discharge Planning process.** First, decide on which elements of the IDEAL Discharge Planning process need to be incorporated at your hospital. Ask clinicians, hospital staff, and patient and family advisors about possible changes.

Adapt Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist to fit your hospital environment. The checklist can be used in multiple ways: Post it on the computer work station in the patient's room as a reminder for all clinicians, make it available at the nurses' station, incorporate the steps into electronic health records, or use it as an observation sheet for continual monitoring. The checklist can also be used in conjunction with existing tools. Nurses at Advocate Trinity Hospital used the checklist to keep track of key tasks in the discharge planning process, along with a separate discharge tool mandated by the Trinity system.

Make sure to clarify roles and responsibilities in relation to discharge planning for each member of the care team: Doctors, nurses, discharge planners, social workers, case managers, pharmacists, interpreters, and so forth. Identify which staff will be responsible for each task and outline clear expectations. Also, be sure to clarify how communication will occur between team members (for example, between the doctor, nurse, patient, and family) about discharge orders and steps toward discharge.

Once this tool is adapted, decide who will review it and what approvals are needed.

### Take It Further ■ ■ ■

The IDEAL Discharge Planning tools are designed for any patient transitioning from hospital to home. However, as you identify areas and set aims for improvement, you may want to consider adding activities (for example, a post-discharge followup call) that focus on patients at the highest risk for readmissions, such as the elderly, those with complex medical and social needs, or the uninsured.

You may also want to develop or adapt educational materials with patient and family advisors to describe common conditions, such as heart failure or high blood pressure, and steps toward discharge in plain language. Taking Care of Myself: A Guide For When I Leave the Hospital, a written discharge summary for patients, is an excellent resource, and is available at:

<http://www.ahrq.gov/patient-s-consumers/diagnosis-treatment/hospitals-clinics/goinghome/index.html>

- **Decide how to use and adapt the checklist and booklet for the patient and family.** Next, adapt the patient and family checklist and booklet, Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet. Ask clinicians, hospital staff, and patient and family advisors about possible changes. At a minimum, insert the hospital name, logo, and tailored information in the brochure. Once these tools are adapted, decide who will review them, what approvals are needed, and how the checklist and booklet will be distributed. The hospital should identify a staff person, such as a bedside nurse, case manager, discharge planner, or patient advocate to responsible for distributing the patient and family tools and scheduling the discharge planning meeting. Consider the following questions:
  - Who will go over the checklist and booklet with the patient and family at the discharge planning meeting? The hospital needs to identify which staff should be involved in this meeting: The nurse, doctor, volunteer or patient advocate, discharge planner, or a combination. The patient should determine if family or friends should be involved and if so, who.

At Advocate Trinity Hospital, certified nursing assistants helped patients write questions in their discharge booklets. Nurses reviewed the booklets with patients before discharge to address any remaining questions.
  - Can the checklist be integrated into the current admission or discharge materials or with the tools distributed in Strategy 2, Working With Patients and Families at the Bedside: Communicating to Improve Quality? If so, how? What approvals are needed?
  - How will interpreters be involved in the discharge planning process, if needed?
  - How will the checklist and booklet be printed? Who will distribute them? Will they be distributed in a folder, online, or another way? How can the messages from the tools be incorporated or distributed via different communication methods such as video; social media, such as Facebook; or cell phone text messages?
  - How will temporary staff learn about how to engage patients and families in the discharge planning process?
- **Plan the IDEAL Discharge Planning training for clinicians.** Decide who will conduct the training. Facilitators should be respected by their colleagues and model the behaviors being asked of them. Which patient and family advisors can help conduct or facilitate the training? How many sessions are needed to train all staff? When can the training be scheduled? Where will it be held? How should the Tool 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning Training be adapted? Who needs to approve the training materials?

A one-page description of the IDEAL Discharge Planning process (Tool 3: Improving Discharge Outcomes With Patients and Families) informs physicians of the new process. This handout can be distributed during physician staff meetings, but physicians also need to take part in training because they are a critical part of the discharge process. Also, make sure physician champions are engaged throughout the implementation process.

During training, recognize that individuals have different learning styles. To be most effective, use three or more different learning strategies during the training, such as giving information, modeling behavior, providing feedback, and practicing skills.

### Step 3: Implement and evaluate the IDEAL Discharge Planning strategy

#### Inform staff of changes

If unit directors and managers are not already involved, tell them about the implementation of the IDEAL Discharge Planning strategy and why it is important. Inform staff at meetings and through posters in common rooms about the changes in the discharge planning process and training opportunities. Specifically, inform physicians at staff meetings or via email of upcoming changes using Tool 3: Improving Discharge Outcomes With Patients and Families.

#### Train staff

Staff training will include those chosen by the hospital to implement the tools (for example, nurses, discharge planners, case workers, and physicians). Training includes a mix of PowerPoint slides and role play. It should take about an hour but can be tailored to the needs of your hospital.

The main messages to emphasize are:

1. To improve safety and quality of care at home, the patient and family needs to be included as a member of the team for all of discharge planning.
2. Discharge planning is not a one-time event with a single fix. It needs to occur throughout the hospital stay.

After the training, it is important to assess:

- Did the training happen as planned? What happened during training that could challenge or facilitate implementation?
- How did staff react to training?

**Distribute tools and incorporate key principles into practice**

As defined during Step 2, identified staff will distribute and go over materials with the patient and family. Make sure all clinicians and hospital staff include patients and families as full partners in discharge planning and prepare them for discharge throughout the hospital stay. Making sure patients and families know what to do and have what they need to succeed at home will result in higher quality discharges with more positive outcomes.

Keep staff aware of the IDEAL Discharge Planning by making sure Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist is available throughout the unit.

**Assess implementation intensely during the first month and periodically after that**

Make sure that all clinicians and hospital staff have the support they need to implement the new discharge planning process and to effectively communicate with the patient and family. Have the nurse manager or other staff leader observe interactions with the patient and family and provide feedback to individual clinicians and hospital staff. Use a standardized form to keep track of the observations, such as the checklist that is a part of Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist. Identify a way to collect and analyze data collected, such as an spreadsheet (e.g., Excel ) or a database.

Continue to conduct periodic observations at 2 and 4 months after rollout to ensure consistent implementation among staff. Continual feedback and monitoring is needed to make sure behaviors become more natural.

**Get feedback from nurses, patients, and families**

Get informal feedback from clinicians, hospital staff, patients, and family members by asking them about how the discharge planning process and the tools can be improved. If applicable, it may be helpful to get feedback from community physicians, especially for those patients who need strong discharge planning support. What worked well? What could be improved? How could tools be changed or adapted for use on another unit? What was critical for success? What was not successful and what could have been made better?

Incorporate formal feedback in mechanisms already in place at hospital, such as patient and family focus groups, patient and family satisfaction surveys, and staff surveys.

**Refine the process**

Share feedback with the implementation team, problem solve, and adapt, as necessary. Using the feedback received, refine the process and tools before implementing on other units.

## Case Study on IDEAL Discharge Planning: Advocate Trinity Hospital

Advocate Trinity Hospital implemented IDEAL Discharge Planning in 2011 as part of a year-long pilot project. This case study highlights key elements of Trinity's experiences with implementation on a 29-bed medical-surgical unit known as 3-South.

**Discharge was once described as the hospital's Achilles' heel.** Trinity implemented IDEAL Discharge Planning to supplement a hospital-wide emphasis on reducing readmissions through more proactive, patient-oriented discharge planning and education. Prior to implementation, CAHPS Hospital Survey and Press-Ganey scores related to discharge were in the single digits.

**IDEAL Discharge Planning led to improved CAHPS Hospital Survey scores on 3-South.** CAHPS Hospital Survey scores trended upward for the 12-month period following implementation, particularly for measures related to discharge and communication with doctors. Hospital leaders viewed the improvements as extremely significant. Nurses on 3-South also reported being more aware of issues related to discharge, including patients' living situations and care needs at home.

**Trinity incorporated patient and staff IDEAL Discharge Planning tools into its existing practices.** Upon admission to the unit, patients received the IDEAL Discharge Planning booklet (Tool 2b) in their discharge folder. Throughout their hospital stay, nurses encouraged patients to read the booklet and ask questions. Prior to discharge, nurses reviewed the discharge booklet with patients and family members. Nurses used the IDEAL Discharge Planning checklist (Tool 1), along with a separate discharge tool mandated by the Advocate system, to keep track of key tasks in the discharge planning process.

**Staff ownership was an important part of implementation.** The unit-based council on 3-South shared strongly in implementation responsibilities. The council, which consists of a small group of nurses who serve as informal unit leaders, provided support to nurses, including coverage so that staff could attend training sessions. In addition, Trinity ensured that certified nursing assistants and unit secretaries participated in training and had a role in implementation. Unit secretaries updated patient discharge folders and reinforced the use of the folders

### Key to Success

- **Senior leaders provided support** by emphasizing the importance of discharge planning
- **Implementing IDEAL Discharge Planning on a single unit** allowed for small-scale successes.
- **Assigning key implementation roles to staff** fostered ownership of the initiative.
- **Mandatory staff trainings** addressed concerns and set expectations.
- **Periodically monitoring nurses** gave nurses helpful and timely feedback.



during daily rounds. Nursing assistants helped patients write questions in their discharge booklets.

**Using a train the trainer model helped motivate and empower staff.**

Training began with nurse managers giving a brief overview of IDEAL Discharge Planning to all unit staff, including staff nurses, certified nursing assistants, and unit secretaries. This overview prepared staff for the upcoming changes on the unit. Then, nurse leaders held a 6-hour training session for selected nurses, including members of the unit-based council and nurses who were working towards promotion. These nurses served as peer trainers, holding 1-hour, small group training sessions with all staff on the unit over a week-long period. The train-the-trainer sessions allowed staff to learn new processes from their peers in a small group environment.

**Nurse managers monitored and supported implementation.** Nurse managers on 3-South conducted weekly huddles with staff to discuss challenges, address concerns, and ensure that discharge planning was happening as intended. They also obtained patient feedback by asking patients and families how involved they felt in the discharge planning process. Nurse leaders communicated this feedback to unit staff during the weekly huddles. Hearing positive feedback from patients helped create a sense of positive change for staff.

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