Feb. 10, 2023

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: Discharge Medications – Discharge Planning Best Practices

An Illinois state legislator recently contacted IHA to express concerns about an incident in which a newly diagnosed Type 1 diabetic patient was unable to obtain insulin in a timely manner after being discharged from an Illinois hospital. With the assistance of family and hours of work, the patient was ultimately able to procure the medication without the need for re-hospitalization. However, the legislator was particularly concerned that such assistance is not available to all patients and asked IHA for assistance and guidance in addressing this concern.

To address this important issue, this memo serves as a reminder to review your hospital's discharge planning policy and procedures to ensure patients and family are included in the discharge planning process and able to secure medications promptly after discharge. We strongly encourage you to incorporate the strategies identified below into your current practice.

Best Practices to Improve Medication Safety at Hospital Discharges

- Implement a "Meds to Beds" bedside medication delivery program for patients prior to discharge. These programs have been shown to improve medication adherence, reduce avoidable readmissions and enhance patient satisfaction.
- If a "Meds to Beds" program is not feasible, call the patient's discharge medication prescriptions into the patient's preferred pharmacy. Let the patient know where to pick up the medication.
- Always review discharge medications with the patient and family and use the teach-back method to ensure understanding. Ensure the patient has a plan and means to obtain discharge medications.
- Implement formal structured processes for medication reconciliation at admission, during care transitions and at discharge, and monitor for compliance. Doing so can reduce medication errors and readmissions.

Best Practices in Hospital Discharge Planning

High quality discharge teaching has been shown to decrease readmissions. Yet nurses, who are most often responsible for patient and caregiver teaching, face challenges including time constraints, patient and caregiver overload, and coexisting comorbidities that add complexity to the patient's care needs at home. IDEAL Discharge Planning can assist nurses and other

providers in improving the discharge process. Readmissions are both a preventable cost and a negative patient experience. Returning to the hospital for care suggests to our patients that they cannot optimally care for themselves without assistance.

Implement the elements of IDEAL Discharge Planning, which encompasses the following actions:

Include:
Include the patient and caregivers identified by the patient as full partners in all education. Care partners should receive the same education and instruction provided to the patient.

Discuss:
Discuss five key areas to prevent adverse outcomes at home:

1. Describe what you expect your patients' experience to be like at home, what they should anticipate as "normal," and what "red flags" they should be alert for.
2. Review all medications, including those just ordered and patients' ongoing medication list for all conditions, not just for their admitting diagnosis/problem.
3. Highlight warning signs and symptoms (red flags) and what to do or who to call when these show up. Anticipate common problems and assess patients for their risk of these problems.
4. Explain test results—what was done while they were in the hospital and what they should know about the results.
5. Either make patients' follow-up appointment or help patients/caregivers in doing so. Explain how a follow-up appointment greatly decreases their risk of readmission. Ensure patients can get to their appointments, and anticipate what they will need to get to their appointment, i.e., mobilization assistance out of their home or transportation adequate for their condition.

Educate:
Educate patients and caregivers with attention to their health literacy, skills and preferences. Use plain language, interpreters, demonstration or written materials based on the assessment of patients' and caregivers' skills. Educate patients and caregivers from the day of admission and at every opportunity during their hospital stay. Use methods of teach-back and show-back to measure the effectiveness of all education provided. Document your education and your patients'/caregivers' responses.

Assess:
Assess patients' and caregivers' understanding of education from the entire interdisciplinary team. Continue to explain all parts of your patient/caregiver education such as the diagnosis, their current condition and the next steps in their care.

Listen:
Listen when your patients and their caregivers express their goals, preferences, observations of their experience, and concerns with going home and caring for themselves.

If you do not hear your patients and caregivers speak to these issues, then ask open-ended questions such as, “Tell me, how are you doing with all of this?” or “What are your goals of this admission?” or “What are your concerns with this discharge plan?”

Resources to Assist with Implementation

Agency for Healthcare Research and Quality. **IDEAL Discharge Planning Overview, Process, and Checklist.** Last reviewed 2017.

Agency for Healthcare Research and Quality. **Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation.** Last reviewed July 2022.

Agency for Healthcare Research and Quality. **Teach-Back: Intervention – Patient and Family Engagement in Primary Care.** 2021.

Huddle for Care. **Meds to Bed Program: A Medication Concierge Service.**

Pharmacy Times. **Implementing Meds-to-Beds in a Community Hospital.** 2016.