Section 4.16 Implement

Patient Discharge Care Coordination Checklist

This checklist provides a list of steps that the care coordinator should follow to ensure that the patient will be supported upon discharge from the hospital or ED.

Patient Discharge Care Coordination Steps

- ❑ Patient has agreed to ongoing care coordination (CC) support and has not declined to share information with community providers and resources. [Describe the benefits of data sharing if this is an issue. See *Patient Recruitment.*]
- ❑ Patient has been given discharge instructions and has demonstrated understanding.
- ❑ Patient has been given a clinical summary of his/her care for future reference, or told one will be made available/supplied within a few days.
- ❑ Medication reconciliation has been performed.
- ❑ Patient has prescriptions or knows they have been transmitted to his/her local pharmacy.
- ❑ Patient has made arrangements to pick up or have picked up medications at the pharmacy.
- ❑ Patient knows what reactions there may be to the medications to be taken and knows how to call the CC with any questions, and when and how to seek emergency help.
- ❑ Patient has transportation to his/her home.
- ❑ Family or caregiver support is present in the home as applicable.
- ❑ Family or caregiver has been involved in the discharge planning and has been or will be involved in the Patient Action Plan development for ongoing care coordination.
- ❑ Family or caregiver location and contact information is known to the CC.
- ❑ Patient has applicable home monitoring devices and has demonstrated understanding of their use.
- ❑ The home environment accommodates any home monitoring or other needed support (e.g., wheelchair, electrical outlets, telephone accessibility). [An Environmental Risk Assessment may need to be performed during a home visit. See *Health Risk Assessments.*]
- ❑ Any Health Risk Assessments recently performed or performed during discharge planning has been reviewed.

Within 24-48 hours of discharge, the CC should initiate a telephone call with the patient to check in and determine that all applicable transitional steps have been taken.

24-48 Hours Post Discharge Transitional Check-in

- ❑ Patient is greeted and asked how things are going. [Ask patient specific questions to encourage patient to relate any uncertainties. See *Supportive Communications*.]
- ❑ Patient (or someone else on the patient's behalf) has picked up medications from the pharmacy.
- ❑ Patient is taking medications appropriately. [If there are any concerns about health literacy, probe more deeply: Ask the patient to identify by name/color/shape/size the pills being taken, when they were last taken, and what they were taken with (e.g., water, food). Ask the patient to review the schedule for taking the medications. Ask to speak to the family or caregiver if the patient needs help organizing and/or taking the medications.]
- ❑ Patient is conducting applicable home monitoring. [If indicated, probe more deeply: If a device is involved in home monitoring, are the devices easy to use? When were they last used? What were the results? If there are issues, ask specifically what they are. Ask to speak to the family or caregiver if the patient needs help installing the devices or using them. If monitoring entails recording food intake, exercise, or other monitoring without a device, ask about these.]
- ❑ If a Patient Action Plan has been developed, check that the patient has it, and/or patient instructions are easily accessible. Ask the patient to review his/her goals and what steps have been taken toward achieving them as applicable. Ask if there are any additional barriers and discuss how those can be overcome.
- ❑ Identify support the CC will next provide to help the patient, and identify how and when the next communication will be made. Ask the patient to repeat the telephone number for the CC and encourage him or her to call (email or text) at any time with questions.

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