Discharge Advocate Training Manual

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1. Introduction

1.1. Project RED

Project RED is a randomized controlled trial taking place at Boston University Medical Center that is exploring ways to best prepare patients for discharge from the hospital. Subjects who enroll in the study will have a 50-50 chance of receiving intervention and support from the *discharge advocate* (DA). After the enrollment and randomization process, the DA will research the subject's medical history, contact the medical treatment team, and meet with the patient for about an hour to appropriately complete the After Hospital Care Plan, which the subject will take home upon discharge and use as a reference for future medical treatment. As part of the intervention, the subject is also called by a pharmacist 2-4 days post-discharge. Subjects enrolled and randomized to the control group receive usual hospital care at Boston Medical Center.

1.2. The Role of the Discharge Advocate (DA)

The role of the *discharge advocate* consists of the following:

- Coordinating with medical team, RNs, and case managers
- Educating patients about their disease
- Educating patients about their medication
- Arranging aftercare with patients & family
- Reinforcing national quality guidelines
- Arranging for medication pick-up, rides
- Preparing and Reinforcing After Hospital Care Plan with patients & family

1.3. The Purpose and Use of this Training Manual

Within the study, the DA uses a *Discharge Preparation and Data Collection Workbook,* to document and track various aspects of the patient's health and health care process. This manual will provide a step-by-step training of the DA's responsibilities while following the format of the Data Collection Workbook. Any reference to the Data Collection Workbook document will be in a table format, with the appropriate explanation needed to complete each section. Any patient/DA interaction with suggested or scripted dialogue will be highlighted using red text. The blue text is variable information that will change from patient to patient. This Training Manual provides a complete step-by-step guide to the RED process. References to the Data Collection Workbook may be disregarded, as the Workbook was used for the sole purpose of the randomized controlled trial at Boston University Medical Center.

2. Getting Started

Prior to the DA's intervention with the patient, the enrollment and randomization process occurs.

2.1. Enrollment

The process of enrolling subjects into the study is done by a trained research assistant (RA). Each morning the RA obtains a list of the admitted patients in the hospital. Following the established criteria for inclusion in the study, the RA will then approach each potential candidate to further assess the patient's eligibility. If the patient is eligible and interested, he/she is consented and given the intake interview.

2.2. Randomization

After the interview is finished, the patient is randomly assigned to the Intervention Group or Control Group. If the patient is assigned to the Control Group, they do not receive any intervention from the DA, and are discharged from the hospital per usual process. However, if the patient is assigned to the Intervention Group, the DA will be notified, and the intervention process begins.

3. Before Meeting the Patient

There is some information the DA must ascertain prior to meeting with the patient. Once the DA is notified of an intervention subject, they will use the printed list of admitted patients to find the subject's Medical Record Number. Using the MRN, the DA can access the subject's medical records and begin to compile the patient's information into the Data Collection Workbook.

3.1. Hospital and Patient Information

Table 3.1

Name _____ **MRN**_____**D.O.B.** _____

Room # _____

Hospital Team info: **Team:** _____

Intern 1:
_____

Intern 2:
_____

Resident:
_____

Attending:
_____

Case Manager Information:

Social Worker Information:

Once the above information is collected, the DA will then contact the treatment team in order to obtain more information about the patient's diagnoses, medications and treatment plan prior to meeting with the patient. The DA should be as knowledgeable as possible in these areas before the initial intervention meeting.

3.2. Contacting the Team

The DA records the number of attempts to contact the hospital team using the template in Table 3.2. If a successful contact was made, the DA marks a check in the checkbox with the time he/she received a call back from the team.

Table 3.2

Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
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Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____
Who (intern,etc)_____Date (m/d/y): _____ Time paged _____ □ call back @ time: _____

4. Contacting the Patient

The DA records the number of times he/she enters the patient's room. The table includes the date, time of day, and length of time talking with the subject to calculate the total minutes spent on the Re-Engineered Discharge.

Table 4.1

#1: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#2: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#3: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#4: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#5: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#6: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#7: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#8: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

#9: DA initials _____Date (m/d/y):_____ Time: ____:_____# of minutes with pt:_____

Total amount of time with patient: _____

It is essential to obtain as much medical information as possible so that the DA can be better prepared prior to the initial meeting. If there is any part of the Data Collection Workbook that can be completed prior to the meeting, do so. If not, then use it as a guideline to shape the intervention meeting.

5. Throughout the Hospitalization

The rest of is used by the DA throughout the patient's hospitalization. It is used to collect and organize information from the patient's medical records, the treatment team, as well as the patient themselves. It will be then be used to prepare the discharge plan and After Hospital Care Plan packet.

A. Diagnosis Information

The information from Table A.1 is obtained from the patient's medical chart, the treatment team, or the patient themselves.

Table A.1

Diagnoses (from chart or team)

Principal Dx 1._____

Secondary Dx: 1. _____ 2. _____ 3. _____

Co-Morbidities: 1. _____ 2. _____ __ 3. _____

PMH:

Is patient a smoker? □ yes □ no □ unknown

Does patient use substances? □ yes □ no □ unknown

List: _____

The *Principal Dx* and any other *Secondary Dxs* are determined by the treatment team and obtained from reviewing the hospital chart, discharge summary, and discussion with the hospital team.

Other existing medical conditions that may or may not have lead to present admission can be found from the admitting History and Physical, Emergency Department notes, and/or the discharge summary. It is best for the DA to also follow up with the patient, as there may be additional information to gather from the patient not yet captured in their medical record.

B. Reconcile Plan with National Guidelines and Critical Pathways

After obtaining the diagnoses information needed to complete Table A.1, the DA will then refer to the Discharge Dx Checklist binder of National Guidelines for the principal diagnosis of the patient. If the principal dx has a checklist, the DA removes a copy from the binder, adds it to the Data Collection Workbook, and fills in the checklist in Table B.1

Table B.1

National Guidelines

Do we have a National Guideline for this diagnosis? □ yes □ no □ N/A

If YES:
Did DA compare it to the plan of care for the patient? □ yes □ no □ N/A

The DA will then determine if there are any discrepancies between the information on the National Guidelines and the discharge plan proposed by the hospital team. If there are items on the list that are not on the proposed discharge plan, the DA will contact the patient's treatment team to discuss potential modifications to the discharge plan. This information is organized in Table B.2.

Table B.2

Were there discrepancies between the guideline and the plan of care for the patient?
□ yes □ no □ N/A

Did DA discuss these discrepancies with a member of the clinical team? (May or may not pass sheet, may be conversation) □ yes □ no □ N/A

The interaction between the DA and the clinical team may be a phone conversation addressing pertinent issues, or may be in person. After this interaction, fill in the information for Table B.3.

Table B.3

Did the team incorporate these suggestions? □ yes □ no □ N/A

If not, was there a legitimate reason why the patient's plan could not be compatible with the guidelines? □yes □ no □ N/A

C. Medical Diagnoses: Discussion and Education

This next section is to be done face to face with the patient. Before entering the patient's room, the DA prints out a copy of the patient education sheet, which includes a basic description and illustration for the principal diagnoses. If necessary, the DA should also review any unfamiliar diagnoses that a patient may have.

The scripted dialogue is as follows:

My name is (name of DA). I am a nurse. My job is to help you make a smooth transition from the hospital to your home. We'll talk about why you are here, answer any questions you may have, make sure you have all of your follow-up appointments scheduled, and that you can get to them. I'll help you understand what your medications are, when and why to take them, and everything else that you'll need once you leave the hospital. When we are through talking, I'll put everything together in a booklet with your name on it for you to take home and bring to all of your appointments. Do you have any questions so far?

Answer any questions the patient may have. Once they fully understand the study and the role of the DA, continue:

I'd like to spend a few minutes with you to talk about the reason that you are in the hospital. Do you mind if I ask you a few questions?

If yes, continue:

Tell me why you are here. Use this communication as an opportunity to initiate a dialogue with the patient and begin teaching them about their diagnosis. If there is anything you don't understand, especially with the medical words, just let me know.

With acknowledgement, the DA continues:

If the diagnosis is unknown, the DA may explore possible causes and explain tests to determine his/her diagnosis. The DA will return to the below section when the diagnosis has been determined by the hospital team.

When the diagnosis is known:
The main problem you are experiencing is called (diagnosis). We call this your diagnosis.

The basic, one sentence explanation the DA would use is found in the After Hospital Care Packet on page one. The DA uses the illustrated diagnosis information from the After Care Packet to further explain the patient's diagnosis. Periodically, the DA checks in with the patient to see if they have any questions, or are confused about anything they are hearing:

Do you have any questions? Is there anything I can better explain for you?

If yes, explain again, using language appropriate for the patient's level of understanding. If no, continue:

Do you think you could describe to me about your "main problem" (or primary diagnosis)?

After the patient describes their diagnosis, the DA clarifies any misconceptions or misunderstandings using a question and answer format to keep the patient engaged.

Do you understand that your diagnosis is called (diagnosis)?

Again, the DA uses the illustrated diagnosis information sheet from the packet to re-explain the diagnosis.

Are you interested in learning more detail about your condition?

If yes, the DA prints out the 3-4 page patient education material describing their specific diagnosis from the hospital's electronic medical record system and give it to the patient.

If no, continue.

After finishing the dialogue with the patient, complete Table C.1.

Table C.1

Medical Diagnosis Education

Did DA educate patient about diagnosis? ☐ yes ☐ no ☐ N/A

By the time of discharge, can the patient describe basic concepts of his/her diagnosis?
☐ yes ☐ no ☐ N/A

Other suggestions for the DA:

Ask patient about any other diagnoses or medical problems they have, if they understand them and the medications they may be taking. This can help the DA begin talking about the patient's current medical problem and medication list.

D. Allergies

The DA asks the patient if they have any known allergies. The DA also checks the patient's medical record to check if the system is updated, and will use this information to fill in table D.1.

Table D.1

Does the patient have any medication allergies?	☐ yes	☐ no	☐ unknown
Is pt being sent home on this med/class (allergy)?	☐ yes	☐ no	☐ unknown
If yes, was this reconciled?	☐ yes	☐ no	☐ unknown

ALLERGIES

Type of Allergy	Reaction	Way to avoid
1.		
2.		
3.		

The DA will engage in a dialogue similar to the one below, for each known allergy.

We have determined that you have an allergy to (type of allergy). When you are exposed to (type of allergy), your body reacts by (type of reaction). The easiest way to avoid this reaction is to know that you are allergic to (type of allergy) and avoid it by (way to avoid) to the best of your ability.

E. Pharmacy: How is the Patient Going to Get the Medications?

The DA will ask the patient where they usually pick up their medication, and fills in the information in table E.1.

Table E.1

Pharmacy

Where will patient fill prescriptions?

- ☐ BMC
- ☐ Community pharmacy: _____
- ☐ Other: _____

Was the plan for how the patient was going to get the prescriptions filled reviewed with the patient? ☐ yes ☐ no

The DA will engage in a dialogue with the patient about any potential problems they may encounter in obtaining their medication, and note this information in table E.2.

Before you leave the hospital, your doctor will give you prescriptions for these medications. Now that we know which pharmacy you will go to, do you have a way of getting there? Either by car, public transportation, or maybe a friend or family member? Is there anything else that might make it difficult for you to pick up your medication?

Table E.2

Was there a problem? ☐ yes ☐ no

What problems filling the prescriptions were identified?

____ no transportation
____ no money
____ insurance issues
____ didn't want to take meds
____ other _____

F. Medication Reconciliation

The purpose of reconciling the patient's medication with the treatment team is to make sure that the patient's electronic medication list and discharge summary reflect the most recent and accurate updates made to the patient's medication plan.

This is done by:

1. Obtaining the current list of medications from *Logician* (the outpatient Electronic Medical Record system used by BMC).
2. The DA will print the electronic medication list and bring it to the patient and ask which medications he/she is currently taking. The electronic medication list may or may not be updated. It is important to have the patient report what they are taking using the list in facilitating conversation.
3. Prior to discharge, the DA will page and contact the treatment team to do medication reconciliation. The steps to do this are located in the DA's Binder. This process takes about 5-10 minutes to update in the computer and is a current JAHCO standard that must be done prior to discharge for all patients. It is ultimately the team's responsibility to do this and make all final decisions.
4. If the team cannot be contacted or is unable to do the medication reconciliation, the DA should meet with the team to give them the appropriate Medication Reconciliation steps, expressing the importance of doing this, and ask the team to leave a copy of the updated electronic medication list with the patient for their After Hospital Care Plan.

After these steps are taken, the DA will report this information in Table F.1.

Table F.1

Medication Reconciliation

Were the medications reconciled in Logician with team? □ yes □ no □ unknown/ suggested to team

Was this list included in the AHCP? □ yes □ no □ unknown

G. Medication Education

The DA will bring the printed medication list of from the Electronic Medical Record system to begin dialogue with the patient about the current list of active medications. The dialogue should instruct the patient about any changes made to medications, doses, or their medication schedule. The DA will also educate the patient about how to use the colored medication table in the After Hospital Care Plan, and provide answers and support to questions and concerns from the patient.

I have a chart of all your medications to take home with you. It has all of the information you need to know about ALL of your medications.

Referencing the patient's electronic medication list prior to reconciliation, Before you came into the hospital, you were taking (name of medication that has been discontinued). You do not need to take this medication any more. Your doctor has given you a new medication to take, because your condition has changed. It is very important that you follow this list (show updated electronic medication list).

Here, in your After Hospital Care Plan (if available), we have included a colored medication calendar for you to follow. If you'll take a look, it is separated by the time of day that you will take each medication. First, there is (name of medication). This is for (state purpose of medication). The best way to take it is (requirements). Each time you take it, you will take (x) pill(s). Each pill is (x) mg. You will take it (how to take it). Hopefully, you won't experience any side effects, but some patients may experience (side effects). It is important to contact (name of PCP) if side effects occur.

Use this chart (if available) at home so you can follow all of the information we just went over. In 2 to 3 days, you will receive a phone call from our pharmacists, who will be able to answer any questions about your medications that you may have. Do you have any more questions now that I can help you with?

Clarify any questions the patient may have, and contact the pharmacist if needed for further education, clarification, dosing, etc. Table G.1. will be filled out after meeting with the patient:

Table G.1

Medications

Is the patient being discharged on any medications? ☐ N/A	☐ yes	☐ no
If YES: Was med teaching completed for all known meds?	☐ yes	☐ no
Was pill box given?	☐ yes	☐ no

H. Diet: Discussion

The DA will look into the patient's chart to determine if they have been placed on a special diet. The doctor or nutritionist may have already discussed their diet recommendations with the patient. If the DA has determined that the patient is going to be discharged on a special diet, continue with the following dialogue:

It looks as though you are going to be going home on a special diet. The food plan is called (name of plan). A doctor or nutritionist may or may not have already gone over this with you. Do you understand how to follow this plan?

If no, Would you like to talk with a nutritionist about how to best follow this food plan?

> If no, stop.
> If yes, the DA will schedule an out patient appointment with a nutritionist, and and insert information into the Appointment Table in the After Hospital Care Plan.
>
> If yes, use the information to complete the Table H.1.

Would you like help with your diet or getting food for when you return home?

> If yes, check with clinical treatment team and add services that are requested.

Table H.1

Diet

TYPE AND DESCRIPTION OF DIET

Name of Diet	Description of Diet

Is the patient being discharged on a special diet prescribed by team? ☐ yes ☐ no
☐ N/A

If YES:

Does patient understand how to follow this plan? ☐ yes ☐ no

If no, did DA educate patient about diet plan? ☐ yes ☐ no

Did DA suggest to team to put in nutritionist order? ☐ yes ☐ no

I. Scheduling Future Appointments: Clarifying Best Times

Before making any appointments, the DA needs to determine which times and days are most convenient for the patient.

With your permission, I would like to set up your follow-up appointments for after you leave the hospital. In the next month, are there any days that you **cannot** have an appointment?

Use this information to complete Table I.1.

Table I.1

Best Time for Appointments

Was the best time for appointments discussed? ☐ yes ☐ no

Patient Conflict Notes:

I will make your appointments and let you know before you leave the hospital when and where they are.

Using the information obtained in Table I.1, the DA will contact the patient's doctors and specialists and make appointments. If appointments have already been made, the DA will change them to be sure they are not scheduled on days the patient is unable to go.

If the patient does not have a PCP, the DA will check with the hospital team. A new PCP will be assigned and a follow-up appointment made, at the discretion of the ward team. The DA will attempt to find a PCP for the patient based on the patient's preference, where the patient lives, and his/her payment source.

J. Coordination of Post-Discharge Appointments with Physicians and other Health Personnel

If the DA has scheduled a PCP appointment for the patient, use Table J.1. to organize the information.

Table J.1

Appointments and Tests Scheduled

POST DISCHARGE APPOINTMENTS

	Name	Reason for appt.	Day/Date scheduled	Time scheduled	Location	# to call to reschedule (DA phone #)	Trans-portation (note if cab voucher given for PCP)
1. PCP							

Is the PCP assignment new (ie, pt came in without PCP) ☐ yes ☐ no ☐ N/A

If applicable:

We have scheduled you for an appointment with your primary care physician, Dr. (name of PCP). Is this the PCP you'd like to see once you go home?

If the patient says no, change their PCP appointment to the physicians they prefer.

This appointment has been scheduled for you to (reason for appointment), talk about how you're feeling, and to make any adjustments to your treatment. It is very important that you see him/her so that he/she is able to make sure that everything is well, and make any changes that are necessary.

Your appointment is scheduled for (date, time, and place of appointment). Does this work for you?

If yes, continue.
If no, revise plan to address the patient's concerns.

If you have nay problems with making this appointment, just let me know and we can figure out how to make it easier for you. It is very important that you go to this appointment.

Do you know where (name of location) is?

If yes, continue.
If no, explain location using hospital map, public transportation map, or driving directions.

Do you know how you will get there?

If yes, Could you tell me?
If no, suggest public transportation, or provide patient with a cab voucher.

The DA should make sure that the patient is able to attend their PCP appointment.

You should bring your discharge booklet that I will give to you to all of your health care appointments. I will put a reminder in your calendar.

If for any reason you are unable to attend or need to change this appointment, please call me, (DA name) to change your appointment. My number is located on the front of your discharge booklet.

If patient has a consultant lab test, or allied health service appointment scheduled:

The DA will follow a similar dialogue and format with each of these appointments as well, and use Table J.2.

Table J.2

2. Consultant (specialty)	(name)	(reason)	(day/date)	(time)	(location)	(DA #)	(transportation)
3. Scheduled Lab/Test							

Were any outpatient tests to be done after discharge? ☐ yes ☐ no ☐ unknown

Also, we have made appointments for you with the following people/services. Dr. (name of PCP) has suggested that you see a (type of service) to help you (name of service). (Name of Specialist) sees many patients from this hospital with this problem, and can be very helpful to you. If you keep this appointment, it will help you a lot.

The DA will go through each appointment with the patient and make sure that they know where it is, why they are going, what they need before they go, and that they are able to make there. If applicable, the DA will also reference the office location using a map.

If the patient has any outstanding lab tests that need to be completed after discharge, the DA will educate the patient about the test, why they have to take it, and set up an appointment to do so. Again, the following dialogue is an example of how this is discussed:

Even though you are ready to leave the hospital, there are still some tests that your doctor would like to do to make sure that everything is OK.

Beginning with the first test, We've scheduled you for a (name of lab test/study). We are doing this test to (explain reason for test). It is very important that you have this test done so your doctor has all the information he/she needs to help you feel better. It is scheduled for (date, time, and place). Does this plan work for you?

> If yes, continue.
> If no, revise plan to address patient concerns.

If you think that you will have a problem making this appointment, just let me know and we'll figure out how we can make it easier for you. It is very important that you have this test done; we want you to feel better.

Do you know where (name of location) is?

> If yes, continue.
> If no, explain location; using hospital map, public transportation directions, or driving directions.

Do you know how you are going to get to the appointment?

> If yes, How will you get there? The DA will use this information to complete the "Transportation" column of Table J.2.
>
> If no, suggest public transportation or provide a cab voucher.

If for any reason you have to change this appointment, please call me at (provide patient with DA's phone number), and be sure to leave a message if you don't get in touch with anyone. One of my colleagues or I will call you back so that we can arrange a better time for the appointment.

When the lab test or study comes back, (name of PCP) will receive your results. It is important you follow up with (name of PCP) to discuss what to do with the results of your (name of test).

The DA will repeat this process for any other lab tests or studies that are scheduled for after discharge.

If the tests are ordered but not yet scheduled: I will call the office tomorrow to schedule your appointment. I will call you on the phone tomorrow, with the date, time, and location of that appointment to make sure you are able to go.

If the patient will be receiving VNA services, the DA will contact the agency ensuring services for after discharge. The DA will make sure appointments meat the best time/dates for the patient, and document the following information in the After Hospital Care Plan:

VNA Services	Agency Name	Address	Phone #	Type of Service

If there are any other appointments, repeat this process, and use the information to complete Table J.3.

Table J.3

4. Other							

Was there an attempt to be sure that all appointments were made at a date/time the patient could keep? ☐ yes ☐ no ☐ N/A

If not, why not? ☐ Only appt. available ☐ Other: _____

K. Lab Tests or Studies with Pending Results: Discussion

The patient may have had tests completed while they were in the hospital, but are waiting to receive the results. The DA will explain which test/studies are still pending, who will be reviewing the results, and when and how the patient will receive this information.

This information can be obtained through the patient's medical chart, as well as speaking with the treatment team and used to complete Table K.1.

Table K.1

Outstanding Labs or Tests

Are any lab tests/studies pending? ☐ yes ☐ no ☐ unknown

PENDING LAB TEST/STUDIES

Lab test/ study name	Date done	Name of clinician to review/location	Day/Date subject will see clinician to discuss results?
1.		Same as PCP	Same as PCP
2.			
3.			

Some tests have been done while you have been in the hospital, but the results are not yet ready. A (test/study name) was done on (date of test/study). (Name of PCP) will review the results and discuss them with you during your appointment.

Depending on the results of your lab test(s)/studies, your doctor might adjust your treatment. We just talked about your scheduled appointment with (name of PCP). It is very important that you see your doctor on (date/time to see PCP) to find out if anything needs to be done or changed as a result of these tests. Again, if there is anything you don't understand or you are having trouble making an appointment, please call me. If I am not there, leave a message and we will call you back.

The DA will discuss the all columns in Table K.1 for each test or study that is pending.

L. Plans for PT, OT, or Speech Therapy: Discussion

The treatment team may have recommended PT, OT, or Speech Therapy for the patient following discharge. The DA can find this information by reviewing the patient's medical chart and talking with the treatment team.

If the patient has plans for PT, OT or Speech Therapy, the DA will complete Table L.1.

Table L.1

Outstanding Labs or Tests

Are any lab tests/studies pending? ☐ yes ☐ no ☐ unknown

PENDING LAB TEST/STUDIES

Lab test/ study name	Date done	Name of clinician to review/location	Day/Date subject will see clinician to discuss results?
1.		Same as PCP	Same as PCP
2.			
3.			

The DA will discuss their plan for follow-up using a dialogue similar to this:

(Name of PCP) has suggested that you have (type of therapy) when you go home. He/She suggests that you (explain suggested therapy). If you do these exercises you are likely to get better faster.

Discuss patient limitations and ways to overcome them (use information from PT/OT/Speech evaluation done while hospitalized; if not ordered, yet the DA feels it is necessary, contact treatment team to potentially order before discharge).

Be sure to describe all columns in Table L.1 for each type of therapy to do at home.

The DA can give basic advice regarding limitations or advice for exercises or movement.

M. Plans for Durable Medical Equipment at Home

The treatment team may have prescribed a piece/pieces of durable medical equipment for the patient to use once home. The DA can obtain this information from reviewing the patient's medical record and speaking with the treatment team. This information will be used to complete Table M.1.

Table M.1

Durable Medical Equipment at Home

Does patient have/need durable medical equipment? ☐ yes ☐ no ☐ unknown

Is the patient clear about how they will get/use this equipment? ☐ yes ☐ no ☐ unknown

If not, did DA talk with CM/RN/SW about clarifying with pt? ☐ yes ☐ no ☐ unknown

DURABLE MEDICAL EQUIPMENT

Equipment Type	Reason for equipment	How will you get it?	When will it get to your home?	Who to contact if a problem?
Home Oxygen				(Name of company)
Walker				
Cane				
Peak Flow Meter				
Glucometer				
Other (specify)				

The DA will discuss the type of equipment necessary and how the patient will get and/or use each piece of equipment. The DA will use the following dialogue:

(Name of team member) would like you to have (equipment type) at home. It will (reason for equipment). You will be given your (equipment type) from (how patient will get it).

If it will be delivered to patient at home, You will get your equipment at home by (how equipment will be delivered/obtained). If you have a problem with the delivery or the equipment itself, please call me at the number I have given you.

The DA should make sure that everything is in place for the patient to receive and appropriately use their durable medical equipment at home.

N. What to do if Problems Arise

It is very important for the patient to know who to contact if a problem arises. The DA should go over this information in Table N.1 with the patient.

Table N.1

What to do if Problems Arise

CONTACT INFORMATION if PROBLEM ARISES

Problem with:	Call (name)	Phone # (day)	Phone # (night)	Map (attached)
1. Anything in your discharge packet	Discharge Advocate	On DC plan	Same	in plan
2. Decline in health	PCP	on DC plan	Same	in plan

The DA should engage in a dialogue with the patient similar to this:

I'd like to talk about a few issues that might come up once you get home. I just want to make sure that you know what you would do if any of this happens.

The DA will review likely or possible situation of potential problems that may occur. He/She will review the content in Table N.1 with the patient.

Some areas to review with the patient include:

a. New medication side effects
b. Acquiring medications
c. Clinical deterioration

O. Discharge Plan: Sign-Off

After obtaining patient information, completing the Data Collection Workbook, meeting with the patient, and creating the After Hospital Care Plan, the DA will use the "Discharge Plan Sign-Off" to ensure all areas were covered.

This should be updated and accurate to make sure all areas are covered for the patient and any other team members who need this information. Once a specific area is covered and completed by the DA, he/she will initial in the appropriate space in Table O.1.

Table O.1

Discharge Plan Sign-off (double check for accuracy)

DA initials that the following have been checked for accuracy:

After Hospital Care plan (cover):

Name _____

Date _____

Medication schedule:

Correct med _____

Correct dosage _____

Correct # of pills _____

Correct route _____

Correct purpose _____

Appointment schedule:

Correct dates _____

Correct time _____

Correct location _____

Calendar:

Correct _____

1 pg dx sheet:

Correct dx _____

Date: __ / __ / __

P. Discharge Plan: Prepare and Give to Patient

The DA will use Table P.1 to document the After Hospital Care Plan, noting whether the patient received the packet, what was included in it, and whether or not the DA was able to explain the AHCP to the patient.

Table P.1

Prepare Discharge Plan and Give to Patient

Notes about d/c plan (any missing info, etc)

AHCP given to patient □ yes □ no

If yes, AHCP included:

- □ Cover of AHCP
- □ Medication Schedule (Project RED)
- □ Logician Med List
- □ Appointment Schedule
- □ Calendar
- □ 1 pg Dx Sheet
- □ Other _____

Packet Explanation:

- □ Entire packet explained to pt
- □ Packet NOT explained to pt

Q. Disposition of Patient Following Discharge

The DA will document the patent's planned post-hospital living arrangements using Table Q.1. The best way to obtain this information is from the patient themselves.

Table Q.1

Disposition

Planned post-hospital living arrangements:

- ☐ Discharged home
- ☐ Discharged – homeless
- ☐ Discharged to Nursing home or other institutional setting
- ☐ Discharged to Rehab facility
- ☐ Patient transferred to other service
- ☐ Discharged home with hospice
- ☐ Patient died in hospital
- ☐ Other _____

R. Hand-off Notes

After finishing with the patient for the day, the DA will document any notes or progress made on the last page of the Data Collection Workbook. He/She should be sure to initial and date each note made. This is essential to make sure any other Discharge Advocates or RED team members are updated on each patient's situation. The DA should also document if any notes have been made on a computer or tape recorder.