How to Deliver the ReEngineered Discharge at Your Hospital

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A note to users: We would greatly appreciate any feedback that you might have on how to improve this toolkit. This information should be directed to Project RED on our Boston University website, www.bu.edu/fammed/projectred/, and leave your comments or questions in the "contact us" section.

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1. The Purpose of this Tool

This tool is intended to be a resource for the Discharge Educators (DE). It describes in detail how to deliver each of the components of the Re-Engineered Discharge (RED) Program. After studying the material, DEs should know:

- The procedures for delivering each component of the RED, including how to create and teach the RED After Hospital Care Plan (AHCP).
- The important communication, educational and relational competencies of an effective discharge process with any patient. For additional techniques on delivering the RED to diverse populations please see the tool entitled, *How to Deliver the ReEngineered Discharge To Diverse Populations*.

2. What is the Discharge Educator (DE)?

The goal of the Discharge Educator (or DE) is to educate and advocate for the patient in order to best prepare him/her and the patient's designated family/household members for discharge and medical success following discharge from the hospital. The DEs are trained specifically to make sure the elements of the RED are followed. The DE collaborates with the medical team about the current hospital course and what needs to be done for a safe transition to home.

The DE works with the medical providers to *organize and teach the discharge plan in such a way that the patient can understand how to care for him/herself once he/she goes home from the hospital.* The DE will work with the appropriate services (i.e., social worker, medical team, case manager, etc.) to identify and address any gaps in the discharge plan developed by the medical team (i.e., diabetic education, visiting nurse, etc.). The DE should work with these other services so as to not duplicate efforts. In general, the DE should:

- Organize and teach the discharge plan that has been developed by the multidisciplinary team.
- Identify and rectify gaps in the discharge plan and add them to the plan.
- Identify patient barriers to discharge plan and strategies to overcome.

In the clinical trial of RED, DEs were registered nurses hired specifically to perform DE functions. For the purposes of this tool, we will describe the RED process assuming that the DE will be responsible for all the components of the RED, with the exception of the post-discharge follow-up phone call. At your hospital, some of the RED responsibilities may be performed by other staff members. For a discussion of these options, see "Step 7: Decide Who Will Provide Patient Discharge Preparation at Your Hospital" in the RED tool *How to Begin the Re-Engineered Discharge (RED) Implementation at Your Hospital*.

2.1. DE Responsibilities at a Glance

The RED consists of 11 mutually reinforcing components that are delivered throughout the hospitalization and shortly after discharge. The chart below summarizes the 11 components of RED and actions the DE takes to implement these components.

RED Component	DE Responsibilities
1. Make appointments for follow-up medical appointments and post discharge tests/labs.	▪ Determine primary care and specialty follow-up needs. ▪ Find a PCP (if patient does not have one) based on patient preferences: gender, location, specialty, etc. ▪ Determine need for scheduling future tests. ▪ Make appointments with input from the patient regarding the best time and date of the appointment. ▪ Arrange for language assistance if needed. ▪ Coordinate appointments with clinicians, testing, and other services. ▪ Instruct patient in any preparation required for future tests. ▪ Discuss reason for and importance of clinician appointments and labs/tests. ▪ Inquire about traditional healers. ▪ Confirm that the patient knows where to go and has a plan about how to get to appointments; review transportation options and other barriers to keeping appointments.

RED Component	DE Responsibilities
2. Plan for the follow-up of results from lab tests or studies that are pending at discharge.	▪ Identify the lab work and tests with pending results. ▪ Discuss and review with patient who will be reviewing the results, and when and how the patient will receive this information.
3. Organize post-discharge outpatient services and medical equipment.	▪ Collaborate with the case manager to ensure that durable medical equipment is obtained. ▪ Assess social support available at home. ▪ Collaborate with the medical team and case managers to arrange necessary at-home services. ▪ Document all contact information for medical equipment companies and at-home services in the AHCP.
4. Identify the correct medicines and a plan for the patient to obtain and take them.	▪ Compare the inpatient medication list with the outpatient medication list, when possible, outpatient pharmacy when needed, and also with what the patient reports taking. ▪ Ascertain what vitamins, herbal medicines, or other dietary supplements the patient takes. ▪ Explain what medicines to take, emphasizing any changes in the regimen. ▪ Review each medicine's purpose, how to take each medicine correctly, and important side effects to watch out for. ▪ Ensure a realistic plan for obtaining medicines is in place. ▪ Assess patient's concerns about medication plan.
5. Reconcile the discharge plan with national guidelines.	▪ Compare the treatment plan with National Guidelines Clearinghouse recommendations for patient's diagnosis and alert the medical team of discrepancies.
6. Teach a written discharge plan the patient can understand.	▪ Create AHCP, the easy-to-read discharge plan sent home with patient. ▪ Review and orient patient to all aspects of AHCP. ▪ Use teach-back to confirm understanding.
7. Educate the patient about his/her diagnosis.	▪ Research the patient's medical history and current condition. ▪ Communicate with the primary inpatient team regarding ongoing plans for discharge. ▪ Meet with the patient, family, and/or other caregivers to provide education and to begin discharge preparation. ▪ Encourage patients to use the "Ask Me 3" and "Questions are the Answer" techniques.
8. Assess the degree of the patient's understanding of this plan.	▪ Assess the degree of understanding by asking patients to explain in their own words the details of the plan (the teach-back technique). ▪ May require removal of language and literacy barriers. ▪ May require utilizing professional interpreters. ▪ May require contacting family members and/or other caregivers who will share in the care-giving responsibilities. ▪ Instruct on a specific plan of how to contact the PCP by providing contact numbers, including evenings and weekends.
9. Review with the patient what to do if a problem arises.	▪ Instruct on a specific plan of how to contact the primary care physician (PCP) by providing contact numbers, including evenings and weekends. ▪ Instruct on what constitutes an emergency and what to do in cases of emergency.
10. Expedite transmission of the discharge summary to clinicians accepting care of the patient.	▪ Deliver discharge summary and AHCP to clinicians (physicians, visiting nurses, etc.) via fax or email within 24 hours of discharge.
11. Provide telephone reinforcement of the Discharge Plan.	▪ Call the patient within 3 days after discharge to reinforce the discharge plan and help with problem-solving. (This may be performed by a PharmD or other staff member.) ▪ Staffs DE Help Line. Answer phone calls from patients, family, and/or other caregivers with questions about the AHCP, hospitalization, and follow-up plan in order to help patient transition from hospital care to outpatient care setting.

3. What is the "After Hospital Care Plan" (AHCP)?

One of the principles of the RED is that all patients should leave the hospital with a printed discharge plan. The discharge plan is a patient-centered planned course of treatment to be given to the patient and used after leaving the hospital. The discharge plan is distinct from the discharge summary which is a summary of the medical aspects of the admission, intended for the medical providers.

For Project RED, we developed a patient-centered discharge plan called the "After Hospital Care Plan" (AHCP). The AHCP is a booklet that is designed by graphic designers and health literacy experts to clearly present the information needed by patients to prepare them for the days between discharge and the first visit with their primary care physician. The AHCP is designed to be easily understood even for patients or caregivers with limited health literacy. The AHCP is finalized, printed and reviewed with the patient on the day of discharge. The AHCP is bound with a spiral plastic binder and each patient is given a magnet with the RED logo (or your hospital logo) so that the patient can hang in on the refrigerator, open to the color-coded calendar of the next 30 days of events or what ever page is most important to him/her. Each patient takes home his/her AHCP upon discharge to use as a reference.

See Appendix B for an example of the AHCP.

The AHCP is a tool that will assist the DE in teaching patients what they need to know in order to take care of themselves when they go home from the hospital. The DE will review each part of the AHCP with patients and confirm that they understand what to do when they go home.

3.1 What are the components of the After Hospital Care Plan?

The components of the AHCP are:

- A **personalized cover page** with the patient's name, date of discharge, name of hospital, and the name and phone numbers of the people to contact with questions: PCP, DE, outpatient case manager, etc.
- Updated **list of all medicines** with appropriate dose and dosing schedule information.
- A list of **medication allergies**.
- A **list of upcoming appointments** to physicians, for tests, when the VNA will visit, etc., for the next 30 days. Includes location of appointments and numbers to call if patient needs to reschedule.
- A 30-day **calendar** that is color-coordinated to the appointments. The calendar also indicates what day to expect a follow-up phone call, prominent cultural and religious holidays as a trigger to the DE and the patient to consider upcoming observances that may affect the keeping of appointments.
- A **diagnosis information** page.
- A **patient activation** page for the patient to record questions, concerns, symptoms to be discussed at the follow-up physician appointment.
- A list of **outstanding test(s) results** (when applicable).

- A list of **durable medical equipment** the patient has and/or needs to obtain or have delivered to his/her home (when applicable). Includes contact information of the company providing equipment, when it will be delivered and/or who to call if there are malfunctions.
- The patient's **advanced directives** for his/her end of life care.
- Recommendations for **diet modifications** (when applicable).

To see an example of the AHCP please go to Appendix A.

4. What is the Patient Information "Workbook" and the RED "Workstation"?

The RED patient information "Workbook" guides the DE step-by-step to ensure the collection of all the necessary information that is needed to complete a RED discharge. Click here to see an example of the Workbook.

The RED "Workstation" is a software program that allows the DE to enter all the information that has been collected in the Workbook. Some of the information can be imported into the Workstation directly from the EMR, therefore eliminating some of the manual entry (please contact the RED staff for how this can be done). Once the information is entered, it is designed to automatically print a personalized AHCP. Using the Workbook, the DE can enter the RED components into the Workstation as the DE gathers information throughout the patient's hospitalization (i.e. appointments, medications, diagnosis, etc). The information in the Workbook correlates with the tabs found in the Workstation to allow information to be easily entered.

If your hospital is not using the Workstation, the DE will use the Workbook to generate an AHCP using a Word template. Click here to see an example of how to create the AHCP for English and non-English speaking patients using a Word template.

5. Preparing to Deliver the RED

The following sections provide a step-by-step training for the DE describing how to perform the RED. For the remainder of this tool, we address the DE directly. In Sections 5 & 7 you will find segments of the Workbook indicating where to document patient information. There are also examples and tips on how to retrieve, document and teach the RED components.

5.1 Obtain and Review Patient Information from Medical Records

Before the first meeting with your patient, be sure to read the medical record to familiarize yourself with the events leading up to the admission, the treatment plan and the hospital course to date. This information is generally in the admission history and physical section of the chart, in the daily progress notes and in any consultation notes.

The first step is to collect pertinent information about the patient using the hospital medical records system. This information includes:

- Patient's age, birth date, sex, inpatient doctor's name and admission date.
- Patient's language preference and possible need for an interpreter and/or translated materials.
- Patient's self-described cultural/racial/ethnic background.
- Diagnosis (admitting diagnosis and co-morbidities).
- Medicine list (including herbal or natural supplements and/or other traditional medicine).
- Medication allergies.
- Sensory deficits.
- Any equipment used or needed at home.
- Tests results and completed tests with pending results.
- Advanced directive and/or health proxy.
- Medical team's discharge plan.

5.2 Confer with the In-hospital Care Team

Before meeting with your patient, be sure to contact the in-hospital care team with whom you will be collaborating throughout the patient's hospital stay. Be sure the team knows your role and keep them informed of your work with the patient. Do not hesitate to ask questions. If any patient information was not available from the medical record system, see if the medical team can fill in the gaps. The following is a list of items to cover with the medical team:

- What is the best way to communicate with the medical team (i.e., pager, email, telephone)?
- When is the best time to check in each day?
- Ask the medical team to confirm the diagnosis(es)

- Is the patient aware of his/her diagnosis?
- Is it okay to discuss the diagnosis, daily plan, discharge plan, and/or appointments needed directly with the patient?
- Confirm the medication list for discharge and communicate discrepancies found.
- Are there any difficulties communicating with the patient, family members or caregivers?
- When is the expected date of discharge?
- Are there any concerns about discharge?

5.3 How to Collect the Information about the Diagnosis

The information about the patient's diagnosis is obtained from accessing the patient's chart (electronic or paper). Be sure to also discuss other co-morbidities with the patient, as there may be additional information to gather from the patient not yet captured in his/her medical record that will be very helpful in preparing the patient for discharge. **Often patients who are readmitted to the hospital within 30 days of discharge are readmitted for a co-morbid condition rather than their principal diagnosis.** If, for example, a patient admitted for chest pain also hypertension, then education about the proper monitoring of hypertension may potentially avoid rehospitalization. Diagnosis information is recorded in the Workbook as shown below.

Diagnoses

Admitting Dx: ___*chest pain*_____

Co-morbidities:__*hypertension, hypercholesterolemia*_____

Discharge Dxs	*chest pain, hypertension, hypercholesterolemia*

5.4 Arrange to Meet with Patient, Family, and Other Caregivers

Meet with the patient as soon as possible (within 24 hours) after admission. This will maximize teaching time while the patient is in the hospital. Discussion with family members and other caregivers is also important to a successful transition. More detail about working with families is found in the tool, *How to Deliver the RED to Diverse Populations at Your Hospital*. Whenever possible, arrange for them to be present when meeting with the patient or arrange to meet with them separately.

6. First Meeting with the Patient

Throughout the hospital stay, you will be educating patients using the components of the RED listed in section 2.1. Studies indicate that patients have difficulty understanding health information that is only communicated verbally. Patients understand and retain about 50 percent of information discussed with their physicians in office visits. Communication is more challenging in the hospital setting where patients are sick, stressed, tired, and often medicated. You can increase the chances that patients will understand and retain what you are teaching them by using the following communication strategies. More information can be found in *How to Deliver the RED to Diverse Populations at Your Hospital*.

During the first meeting with the patient, you will provide an introduction to the RED and the role of the DE. Tips for the first meeting include:

- Ask permission to enter the patient's room.
- Introduce yourself by name and identify your role.
- Determine if the patient feels well enough to participate.
- Ask the patient how he/she prefers to be addressed.
- Ask about language preference.
- Assess for language assistance needs and contact interpreter services as needed.
- Speak slowly.
- Use plain, non-medical language.
- Actively listen; do not interrupt.

Do not overload the patient with lots of information at once; do not try to cover more than 3 key points at a time.

Some tips for effective communication strategies that you can use when you meet with your patients include the following:

- Be attuned to body language.
- Offer encouragement: **"**You did the right thing by coming to the hospital."
- Express empathy: "It sounds like you've been through a lot."
- Build self-confidence: "With practice you will be able to check your sugar levels accurately."

6.1 Orientation of the patient to the RED Program

It is helpful that the patient and involved caregivers understand your role as the DE and how you will be assisting the patient make a safe and smooth transition from hospital to home. Recognizing the benefits of having a DE will help fully engage the patient and the caregiver in the RED process. When describing the RED and the role of the DE, be sure to emphasize the following points:

- A safe and well-planned discharge from the hospital reduces the risk of returning to the hospital.

- Often there is a lot of new information to learn and remember before leaving the hospital and many patients find this to be challenging.
- The DE will help you learn the essential new information you will need to make a safe transition from hospital to home.
- The DE will send the AHCP and discharge summary to your primary care doctor to help ensure the smooth transfer of care from the hospital doctors to your primary care doctor.
- Your DE will teach you the important things you need to known about your illness, your medicines, your follow up appointments and what to do if you run into problems after returning home.
- Your DE will answer all of your questions.

6.2 Gather Information from the Patient

Once the patient fully understands your role as the DE, continue engaging the patient in discussion that will help you to gather and confirm essential details needed for constructing the AHCP.

The essential information to gather from the patient includes:

- Primary care clinician's name and office location.
- Patient's understanding of illness and treatment.
- Medicines taken at home prior to admission.
- Names of family, caregivers, and social support persons.
- Pharmacy name and location.
- Medication allergies.
- Advanced directives.
- Durable equipment he/she has/should have at home.

This information is then recorded in the Workbook.

6.3 Daily Interactions with the Patient

The goal of the follow-up patient sessions is to teach and reinforce important health and treatment plan information, and to identify and address discrepancies between and/or barriers to the clinical team's discharge plan and the patient's understanding of the discharge plan. Following the initial meeting, you will make a plan with the patient to return to teach essential elements of the RED and address any new concerns. Encourage patients to identify someone who can support them during their transition to include in the conversations.

You will not always have the opportunity to teach and reinforce ALL identified elements for each patient. This will often be due to short hospital stays. You will need to assess and prioritize what you will cover based on factors such as:

- Patient's needs, requests and receptiveness.

- Gaps in the discharge plan.
- Patient’s involvement in community services.
- New problems/diagnoses versus old.
- What can parts of the education can be done after discharge.

The post discharge telephone call can be used to reinforce those elements of the discharge that were not fully covered by the time of the discharge.

7. Deliver the In-hospital RED Components

The following sections give examples and tips on how to retrieve, document and teach each component of the RED Program. The sections below show examples from the DE Workbook, which correspond to the sample AHCP.

7.1 Make Appointments for Follow-up and Post-Discharge Tests/Labs

Arranging for a post-discharge appointment to follow-up on the ongoing medical issues is one of the most important components of the RED. The post-hospitalization appointments include not only physicians (primary care physician, specialists, etc.) but also appointments for tests that have been scheduled for after discharge, dates that the Visiting Nurse will visit the home, day and time that the home-oxygen company will deliver the oxygen, date and times to go to the "Coumadin Clinic," etc. All this information is entered into the Workstation and will be printed on the AHCP's appointments page and also on the 30-day calendar. The next section discusses important concepts related to making appointments that are convenient for patients.

7.1.1 Determine Best Times for Appointments and Make Appointments

Before making any appointments, it is helpful to determine which days and times are most convenient for the patient and whoever else might be assisting with the transportation.

Ask the patient about:

- Days or times when appointments should not be booked.
- Days and times that are particularly good.
- Any potential problems keeping appointments.
- Transportation options.
- Whether any friends or family members will be involved in the appointment or transportation.
- Whether an interpreter will be needed (for more information please see *How to Deliver the Re-Engineered Discharge to Diverse Populations*).

If the AHCP is printed using the RED Workstation, then the 30-calendar automatically lists the national and religious holidays or observances. Appointments should be made to avoid these conflicts. You may say something like:

> "I will make your appointments according to your schedule that we discussed. I'll be back to make sure they will work for you and if not, I'll change them. I'll also make sure you know how to get to them."

Use the information gathered above to complete the corresponding Workbook sections as shown below.

> **Post-Discharge PCP Appointment**
>
> _*YES*___ **Subject has PCP**?
>
> Preferences (gender, location)? _____

Patient requests for PCP appt (weekdays, time of day)**:** *Tuesday mornings*

Team requests for appointments: *cardiologist and rheumatologist*

PCP Name	Day / Date / Time
Brian Jack, MD	*Tuesday, October 24th at 11:30*
Clinician to see at appt (if not PCP)	**Clinic Location / Phone #**
	BMC, ACC 2nd floor 617-444-2222

Does subject have transportation to PCP appt? ___√ Yes

___**No** ____ Transportation options discussed

For other appointments, tests or lab work, use the information gathered above to complete the Workbook sections below.

Additional Appointments, Tests, or Lab Work after discharge

Day/Date/Time	Phone and Fax #	Reason/Test/Lab
Thursday October 26th 3:20pm	*617-444-777 Fax: 617-444-7000*	*Arthritis*
Provider	**Location**	
Dr. Jones	*BMC, DOB 5th floor*	

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Wednesday, November 1st at 9am	*Ph: 617-555-1234 Fax: 617-555-1235*	*Heart condition*
Provider	**Location (Building, floor)**	
Dr. Smith	*BMC, DOB 4th floor*	

7.1.2 What if the patient does not have a Primary Care Physician (PCP)?

If the patient does not have a PCP, check with the clinical team or with hospital administration to learn how new PCPs are assigned at your hospital. Typically, PCP assignment does not require a referral. With some insurance programs, however, the patient may have been assigned a PCP without the patient's knowledge, so it is worthwhile to call the insurer to check. Attempt to find a PCP for the patient based on the patient's preferences, where the patient lives, and his/her payment source (i.e., make sure the PCP accepts the patient's form of insurance or will treat uninsured patients). Ask the patient if he/she has any preferences such as gender or language the PCP speaks when deciding on a new PCP. Once a PCP is assigned, make a follow-up appointment (preferably to be seen no later than two weeks after discharge) to aid in a safe transition to the ambulatory setting. Ensure that there are no conflicts among multiple appointments.

7.1.3 Make Appointments for Lab Tests or Studies to be Done After Discharge

If the patient has any outstanding lab tests that need to be completed after discharge, teach the patient and/or a caregiver about the test, its importance, and arrange scheduling as needed. Confirm that your patient is able to attend the appointment, obtain transportation and understands what to do if a conflict arises. The section of the Workbook for tests to be done after discharge is shown below:

Labs / Tests to be done post-discharge	Date Scheduled	Follow-up
Cardiac Stress Test	*January 1, 2011*	*PCP, Dr. Smith, will follow the results*

7.2 Follow-Up of Lab Tests or Studies that Are Pending at Discharge

An important component of the RED Program is to ensure that there is a good follow-up for tests done in the hospital but the results of which are pending at discharge. There is good evidence that these pending tests are frequently not followed-up and that many of these tests are actionable.

Pending tests can be obtained through review of the patient's medical chart, the hospital laboratory reporting system and by speaking with the clinical team. When the information is identified, it can be recorded in the RED Workbook as shown below:

Outstanding Labs/Tests

Labs / Tests Pending	Date Conducted	Results expected	Who will follow up the result
Stomach biopsy to test for H. pylori	*10/19*	*10/21*	Dr. Jack (appointment on Oct 24th)
Angiotensin-Converting Enzyme	*10/19*	*10/23*	Dr. Jones (appointment on Oct 26th)

When discussing with the patient, explain that some test results are still not ready. Point out where these tests are noted in the AHCP. When the AHCP is printed, the pending tests will be identified. When you teach the AHCP, you can explain which test/studies are still pending, who will be reviewing the results, and when and how the patient will receive this information. You can say something like:

> "Remember having (test/procedure/studies) done? You will be ready to leave the hospital before the results from (that/those) will be back. We will put them on your AHCP to remind you to ask your doctor about the results when you see (him/her) on (date)."

7.3 Organize Post-Discharge Outpatient Services and Medical Equipment

7.3.1 Outpatient Services

The discharge plan for many patients might include a recommendation for a visit by a nurse or a physical, occupational or speech therapist to the home following discharge. These visits are printed in the AHCP in the appointment section and also appear in the 30-day calendar. When teaching this information, you can refer to the therapy evaluations done in the hospital to illustrate the plan for outpatient therapy. The section of the Workbook below describes how to record the post-discharge home services.

Information on Outpatient Services

Current or New Outpatient Services (ex. VNA, PT)? None

VNA services following discharge? No Yes _____

PT, OT, ST (circle) services following discharge? No Yes_____

7.3.2 Medical Equipment

For many patients being discharged, there is also a need to coordinate and teach the patient and caregivers about any medical equipment that will be needed in the home after discharge. You will obtain this information by reviewing the patient's medical record and speaking with the clinical team. For example, some patients will need oxygen to be delivered to the home. Enter into the Workstation the relevant information about when the equipment is going to be delivered. This will be displayed in the medical equipment section of the AHCP.

Examples of medical equipment are:

- Hospital bed
- Commode
- CPAP mask and equipment
- Wheelchair
- Oxygen
- Home nebulizer
- Peak flow meter
- Glucometer
- Scale

The Workbook section used to organize outpatient equipment is shown below.

Durable Medical Equipment needed at home? **No** __ **Yes** ✓
New durable medical equipment ordered: **No** __ **Yes** ✓

Type: **Hospital Bed**

Company name: **Martin Inc.** Contact: **Jessica Martin**

Address: **1 Boston Medical Center Place** Phone: **617-414-1234**

When reviewing the AHCP you can discuss the importance of each piece of equipment. When possible, use actual examples of the equipment, such as a peak flow meter or glucometer, for more effective demonstration of how to use the equipment.

7.4 Identify the Correct Medicines and a Plan for the Patient to Obtain and Take Them

Two of the most important components of the RED are to (1) identify the correct medicines that the patients should take (and not take) after discharge and (2) to arrange for the patient to able to obtain the medicine.

The purpose of medication reconciliation in preparation for hospital discharge is to determine that the patient's discharge medication list and discharge summary medication list reflect the most recent and accurate updates made to the patient's medication plan.

> "We want to make sure that when you leave the hospital, you have a list of all the medicines you should be taking. To do this, you and I will go over the list the hospital has and if needed, the list your outpatient primary doctor has and maybe even talk to your pharmacy so that we can make sure everyone has the correct list."

Some tips for discharge medication reconciliation are:

- Obtain the current list of medicines from the outpatient medical record (when available) and from the inpatient chart, and, in some cases, from local pharmacy records to determine what medicines the patient has been taking.

Review the list when you first meet the patient to determine what he/she is taking. You should also ask if the patient plans to use any other types of treatments along with the medicines such as herbs or dietary supplements, or acupuncture. This can identify potential interactions with prescription medicines. If you are not sure about potential interaction risks, you can consult with a Complementary Alternative Medicine specialist or website resources, such as http://nccam.nih.gov/, for more information. More information can be found in *How to Deliver the RED to Diverse Populations at Your Hospital*.

- Discuss any discrepancies with the clinical team and identify what medicines the patients should and should not be taking. Before discharge, resolve all discrepancies discovered in the medication list.
- If your hospital inpatient unit has access to the outpatient EMR, this should be updated with the current medication list.
- Once finalized, a print out of the EMR list of the medicines is attached to the Workbook and entered into the Workstation. This should be done as soon as possible because waiting until the day of discharge makes this process error prone.

7.4.1 Identify Problems that the Patient Might Have in Obtaining Their Medicine

Explore if there are any potential problems for the patient obtaining the medicines. The section of the Workbook that will help you identify this information is below.

Engage in a dialogue with the patient that could include statements such as:

> "How will you get to the pharmacy to pick up your medicines - either by car, public transportation, or maybe a friend or family member?"
>
> "Is there anything that might make it difficult for you to pick up your medicines?"

If the patient identifies potential problems with obtaining the medicine(s), then you can engage in a problem solving conversation to assist in identifying a plan that will be successful. Sometimes it is necessary to discuss these issues with other family members and to elicit their support. For medicines for chronic conditions, explore mail delivery options. It will be helpful for you to have a resource list of pharmacies in the area that will deliver medicines and medical supplies. If unable to find a way to obtain prescriptions, collaborate with the case manager or social worker about how to obtain these medicines.

Pt. plan to pick up meds upon d/c: ***wife will drive him to the pharmacy***

Community Pharmacy Name	Phone #, Street address, City
CVS Pharmacy	1500 Lincoln Ave., Boston, MA 02121 (617) 555-8888

Pt. requests pill box? **No** ____ **Yes** _√__ **(Pill box given** _√___**)**

For information about financial barriers to obtaining medicines, see *Tool 19 in the Health Literacy Universal Precautions Toolkit*.

7.4.2 Medication Allergies

All medication allergies are confirmed with and documented in the Workbook, entered into the Workstation and appear in the AHCP. In order to identify the allergy history accurately, review the patient's medical record and inquire about any additional allergies that have not been documented. For example you can say:

> "Did you ever have a bad reaction after you took a medicine, such as an itchy rash or trouble breathing?"

If a patient is prescribed a medicine appearing on the allergy list, or a medicine in the same class, confirm the medical team's awareness of the allergy; in most cases an alternative medicine should be prescribed. The section of the Workbook that documents allergies is below.

Documenting Medication Allergies

Allergies _Y___ **No known allergies** ____

Allergy	Patient Confirm (Y/N)	If no, explain	Allergy	Patient Confirm (Y/N)	If no, explain
Motrin	Y				

7.5 Reconcile the Discharge Plan with National Guidelines

The purpose of the RED and the role of the DE are to "package" and teach the discharge plan that has been determined by the clinical team. The hospital discharge, however, provides an important opportunity to be sure that the patient is on the optimal treatment plan. Studies have shown that many patients are discharged from U.S. hospitals on treatment regimens that do not follow national recommendations for the patients' conditions. For this reason, we believe that identifying and rectifying these inadequacies is an important component of the RED.

Once discharge diagnosis is known, we recommend that you refer to the National Guideline Clearinghouse at AHRQ (http://guideline.gov/) for the main diagnosis and any relevant secondary diagnoses. Reviewing the Clearinghouse information for the patient's diagnoses can help determine if there are potential discrepancies between the national guidelines and the discharge plan proposed by the clinical team.

If there are potential discrepancies, you should then contact the clinical team to discuss potential modifications to the discharge plan. Remember, your patient will benefit from these "double checks." The discussion with the clinical team can go something like:

> "When reviewing the AHRQ National Guideline Clearinghouse I noticed that most patients with (specific diagnosis) are discharged on (medicine). Is there a reason why we shouldn't add this to the treatment plan?"

7.6 Teach the Content of a Written Discharge Plan the Patient Can Understand

Once you have gathered and entered all the information, first into the DE Workbook and then into the Workstation or Word template, you will print a final AHCP to give to your patient. You can then sit with the patient and carefully discuss each page of the AHCP. The following four sections give tips about how to teach the patient about the diagnosis, medicines, and appointments, and how to encourage question asking. Please note that teaching the AHCP will happen throughout a patient's admission, so much of the teaching on the day of discharge is reviewing information and assessing the patient's understanding.

7.6.1 Teach the Patient about his/her Diagnosis

When the AHCP is printed, it will contain educational information about the diagnosis and other co-morbidities. Whenever possible, provide patient education materials in the patient's preferred language. The DE should ask the medical team if the patient is aware of his/her diagnosis before discussing the diagnosis with the patient. Be careful of certain cultural contexts when educating the patient about diagnosis and treatment. (See *How to Deliver the RED to Diverse Populations at Your Hospital*.)

Patients may have beliefs about what their problem is, what caused it and what treatment is needed. Before teaching about their diagnosis or co-morbidities, ask the patient about his/her health beliefs. The RED studies show that up to half of patients are not following the discharge plan 2-3 days after discharge. Up to one-third of these are patients who have decided that they are not going to take the medicines prescribed. Thus, exploring the health beliefs can assist in treatment plan adherence. An open-ended question that allows for a more detailed response from the patient might be helpful. For example you might ask,

> "What do you think has caused this problem? What do you think will

help you get better so that you don't have to come back to the hospital?"

Begin teaching the patient about their diagnosis. For example, you might ask:

> "The tests have helped the doctors find out what's going on with your body. Would you like me to explain this? To you"

Once you have the patient's permission to deliver information, you can say:

> "The reason you (symptoms/problem) is because you have (diagnosis). This is called your diagnosis. May I tell you more details about your diagnosis?"

If yes, give the RED illustrated diagnosis information sheet (see example in Appendix B) describing his/her specific diagnosis to the patient and use it as a teaching guide. You can help the patient understand why the diagnosis information is important. A few tips include:

> "It can help you to better understand why it is important to take your medicine and keep your appointments."

> "It allows you to talk with your family, friends, etc. who might be able to help you if they have a better idea of your condition."

> "It will help you make better decisions about your care."

If the patient asks for clarification, explain again, using language appropriate for the patient's level of understanding. See section 7.7.1 for tips on how to confirm comprehension. Once you are confident that the patient has an understanding of his/her diagnosis, you can then move on to the next component.

7.6.2 Teach about the Patient's Medicines

Bring the AHCP which lists all the medicines to the patient's room for teaching. You will cover:

- Any changes to medicines (new medicines, change in dose or frequency, etc.).
- The correct dose.
- The time of day to take them.
- The reason he/she is to take them.
- Importance of bringing all medicines to follow-up appointment.
- Which medicines to continue taking and which to discontinue.
- How long to take it for (even if symptoms go away).
- Potential side effects.
- Not to discontinue without calling the doctor.
- Importance of bringing all medicines to follow-up appointments.

7.6.3 Teach the Appointments

After you have confirmed the patient's follow up appointments, review the details with the patient.

Review:

- Appointment date, time and location.
- How the patient will get there and provide maps and directions, if needed.
- The purpose of the appointment.

Remind your patient:

- If for any reason a conflict arises and he/she needs to change an appointment, to call the doctor's office to change the appointment.
- The contact information will be located in the AHCP.
- To bring the AHCP to all appointments.

7.6.4 Encourage Questions

Patients can feel ashamed to ask questions and often are not even sure what questions they need to ask. To address this, the AHCP contains a page that helps guide the patient to prepare for his/her outpatient primary care appointment, and it encourages the patient to write down questions or concerns. The DE can review this page in the AHCP with the patient and describe its purpose. Family members can contribute to this page, as they too may have questions, concerns or observations of their own.

Ask Me 3 was developed to help promote effective communication between patients and providers in an effort to improve patient understanding. We recommend using this technique in teaching the AHCP. The program encourages patients to know three things before leaving the medical encounter:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

For more information go to: http://www.innovations.ahrq.gov/content.aspx?id=163

The patient should also be encouraged to ask as many questions as he/she needs to in order to completely understand the AHCP. **Questions Are the Answer** is a campaign created by AHRQ to encourage patients to get more involved in their healthcare by customizing lists of questions about how to find a clinician, starting new medicines, deciding on a treatment, etc. Building a list of personalized questions can empower patients to ask the questions that will elicit the information necessary to make informed decisions.

For more information, go to: http://www.ahrq.gov/questionsaretheanswer/index.html

7.7 Assess the Degree of Patient Understanding

When asked, "Do you understand," patients will frequently say, "Yes," whether they understand or not. Therefore, an important component of the RED is to confirm that patients actually understand what they

are supposed to do to take care of themselves once they go home. If they are unable to understand, then it is necessary that someone assist them at home or that anther plan be implemented. To ascertain when a patient understands what you have taught, use the "Teach-Back" method, an evidence-based communication strategy described below.

7.7.1 Teach-back

One of the easiest ways to close the communication gap between patients and educators is to use the "Teach-Back" method. Teach-back is a way to confirm that you have explained to the patient what he/she needs to know in a manner that the patient understands. Patient understanding is confirmed when he/she explains the information back to you. When using teach-back to review medicines it is helpful to have patients actually show you how they will take it, in addition to explaining in words. Research has shown that patients who successfully teach-back their medicine instructions still sometimes make mistakes when asked to demonstrate how they will take their medicines. To view a video demonstration of the Teach-Back method, go to www.nchealthliteracy.org/teachingaids.html. Some points to keep in mind include:

- This is not a test of the patient's knowledge; it is a test of how well you explained the concept.
- Be sure to use this technique with **all** your patients, including those who you think understand as well as those you think are struggling with understanding.
- If your patient cannot remember or accurately repeat what you asked them, clarify the information that you presented and allow them to teach-back again. Do this until the patient is able to correctly describe your directions in their own words.

For example, you can utilize the teach-back method after teaching the patient about:

The Diagnosis:

> "I not sure I explained things clearly. Can you tell me how you would describe your illness?"

The Medicines:

> "I know the information about the medicines can be very complicated; let's make sure I've explained this clearly. Can you describe and also show me how you will take your (ask about a specific medicine) when you get home?"

The Appointments:

> "Can you tell me where and when your first doctor's appointment is?"

Remind the patients that all the information they need to know is in the AHCP and they simply need to know where in the AHCP the information is located. After reviewing how to locate the information in the AHCP, ask a series of other questions. If the patient has trouble describing how to take the medications, the clinical team should be notified and an alternative plan should be created.

7.7.2 What If My Patient Cannot Understand the Discharge Plan?

Patients who are unable to demonstrate understanding of the discharge plan are likely to have difficulty once they go home. If your patient cannot demonstrate an adequate understanding of the discharge plan then a new plan must be developed.

In some cases this will include being sure that your patient receives care and support from family, friends, or other caregivers once he/she returns home. In this situation, you can ask the patient if there is any person he/she would like to be informed of the discharge plan. When identified, arrangements should be made to orient the caregiver to the AHCP. When possible, have the caregiver present during teaching sessions.

Remember to obtain the patient's written HIPAA permission to share health information with an identified caregiver.

In some cases this will involve eliciting more family involvement than was previously necessary. At times, involving the family can lead to potential conflicts. If engaging the family has been difficult, or if the household is a source of conflict or stress, involving social work might be particularly important to assist with the assessment and potential intervention, in an effort to improve communication with and support for the family and to organize a safe discharge.

7.8 Review What to Do if a Problem Arises

In the RED studies, we heard over and over from patients that what worries them most about leaving the hospital is that they will not be able to reach their doctor (or any other responsible clinician) if they have a problem. For this reason, an important component of the RED system is that each patient be told before discharge how they can contact a medical provider if a problem arises after discharge.

You might try one of the following to initiate this dialogue:

> "Let's talk about what to do if you think you're feeling worse."
>
> "How about if you think you're having a side effect from a medicine?"
>
> "What should you do if you're not sure you can get your medicine?"
>
> "I just want to make sure that you know what you should do if any of this happens."
>
> "If your caregiver has concerns or questions, let's make sure s/he knows how to reach us too if that's ok."

When raising this topic, you might engage in a dialogue with the patient such as:

> "I'd like to talk about a few issues that might come up once you get home. I am confident that you'll do very well once you are home, but just in case there is a problem, here are some phone numbers where you can get help."

Then show the front of the AHCP where the information on how to contact the PCP is listed and reinforce the importance of calling the PCP if problems arise.

Review potential problems that may occur. Some areas to review with the patient include:

- New medicine side effects.
- Difficulty acquiring medicines.
- Clinical deterioration.

8. Post-Discharge Components of the RED

8.1 Transmit the Discharge Summary to the Post-Discharge Clinician

Another important component of the RED is to ensure that the clinical information from the hospitalization is transmitted to the clinician who is responsible for caring for the patient after discharge. When the clinical information is not properly transmitted, the "receiving clinician" is unaware of important clinical information and proper ongoing care of active medical issues is in jeopardy. This is a significant patient safety and clinical quality issue.

For these reasons, part of the RED program is to transmit the patient's hospital discharge summary and the AHCP to the primary care provider within 24 hours after discharge. This allows ample time for the provider to review this information before a patient's follow-up appointment. Furthermore, if a patient has a problem or question between the time he/she leaves the hospital and the day of the follow-up appointment, then the PCP will have the information about the hospitalization and can respond to questions or concerns.

This information can be transmitted by fax or email. It is important to discuss the preferences of the outpatient providers to determine the best mode of transmission.

One barrier to transmitting the discharge summary is that the discharge summary at many hospitals is not prepared until much later after discharge – in many cases, not until 30 days after discharge. If this is the case at your hospital, then it is very important that you work with your hospital administration, nursing and medical leadership and patient safety officer to ensure that policies are in place to ensure that discharge summaries are completed in a timely way. In any case, be sure to transmit the AHCP within 24 hours of discharge.

8.2 Provide Telephone Reinforcement of the Discharge Plan

The final component of the RED is to reinforce the content of the discharge by calling the patient at home in the 2-3 days after discharge. It is important to note that this call is not a "social call" but an action-oriented call that is designed to identify problems or misunderstandings that have developed after discharge and to organize a plan to address these issues. The options for who should carry out this task are described in the RED tool entitled "How to Get Started with RED." The content and procedures of the post-discharge telephone call are described in the RED tool entitled "How to Conduct a Post-Discharge Follow-up Phone Call."

9. Other Teaching Opportunities Included in the AHCP

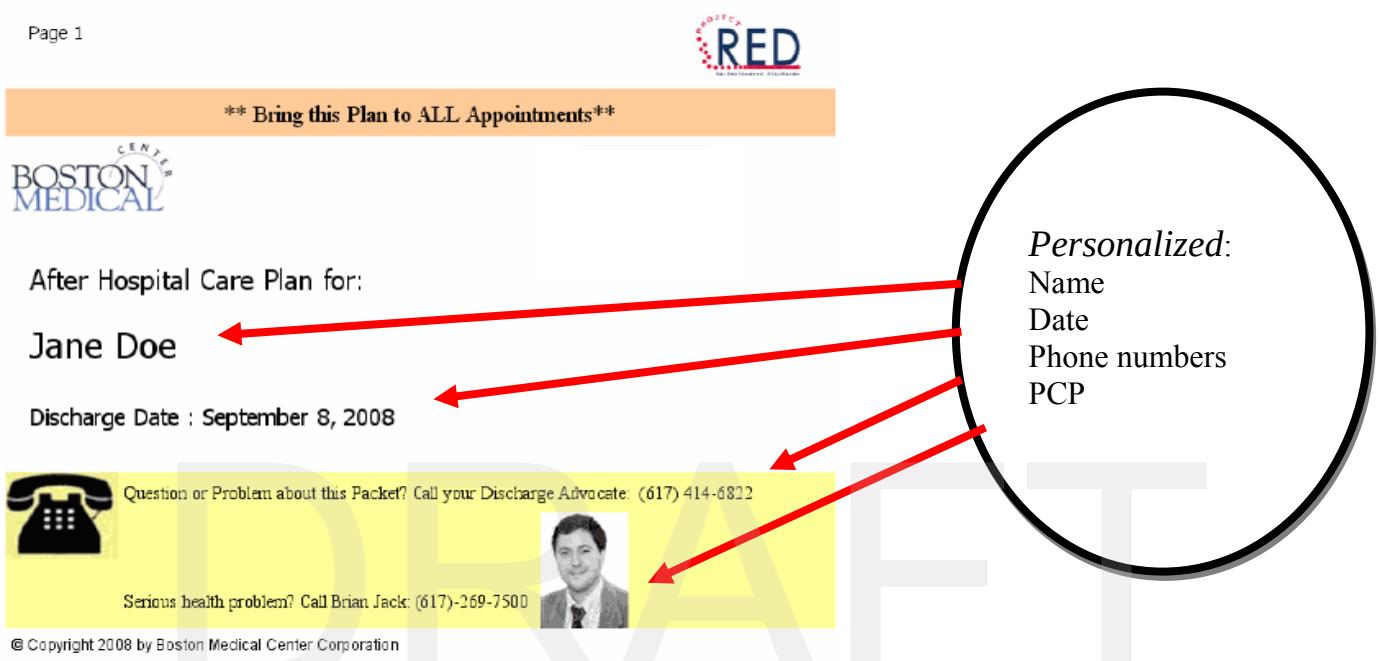
The AHCP provides other opportunities to assist the patient before discharge. These are contained in the Workbook, can be entered in the Workstation and are printed as part of the AHCP. These items include:

- **Dietary Advice** – Dietary advice can play an important role in preventing readmission. For example, diet can impact anticoagulation therapy, glucose control or response to congestive heart failure treatment. You can review the patient's chart to determine if the patient has been placed on a special diet and reinforce it using the teach-back method.
- **Substance Abuse and Smoking Cessation:** It is beyond your role to screen for substance or alcohol abuse, but when these conditions are already identified in the medical record, you can address whether the patient is interested in treatment and, if so, add this information to the AHCP.
- **Predicting the Risk of Readmission:** In the course of the RED research studies, we have identified several factors that are risk factors for readmission. The RED team is working on ways to identify those patients who are more likely to be readmitted so that additional resources can be directed at those at highest risk of readmission. Some of these factors include depressive symptoms, limited health literacy, frequent hospital admissions, unstable housing, and substance abuse, among others. More information about predictive models for readmission can be requested from the RED team. More information about this topic can also be found in the RED tool *How to Measure Your Hospital Readmission Process.*

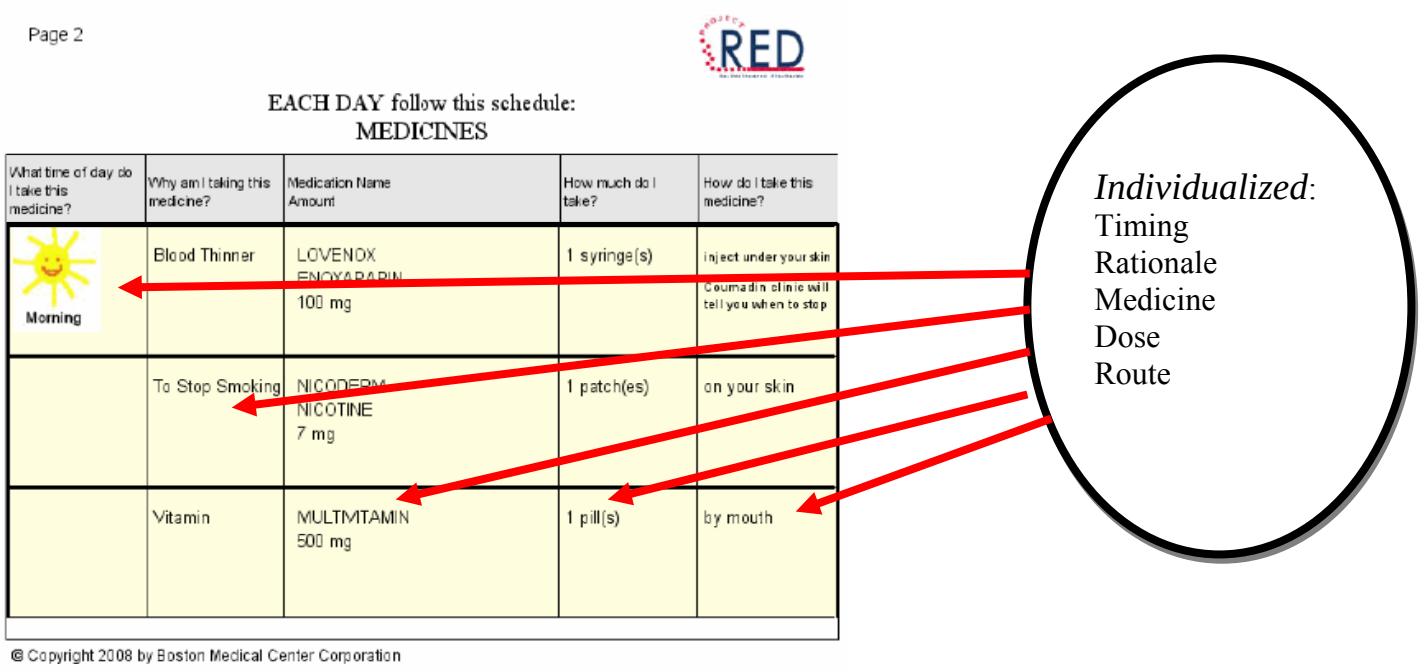
APPENDIX A

Components of After Hospital Care Plan (AHCP)

AHCP Example: Cover page



AHCP Example: Medicine schedule



AHCP Example: Appointment Page

Bring this Plan to ALL Appointments

Jane Doe

What is my main medical problem?

Pulmonary Embolism

When are my appointments?

Wednesday, September 10, at 2:00 pm	Every Thursday, beginning September 11, at 10:00 am	Saturday, September 13
Dr. Brian Jack PCP follow-up	Dr. Michael Paascheorlow Psychiatrist	Coumadin clinic
South Boston Community Health Center 2nd Floor 409 West Broadway South Boston, MA	BMC - Behavioral Health Outpatient Services Dowling Building 9th floor 850 Harrison Ave. Boston, MA	BMC - Family Medicine Yawkey Ambulatory Care Center 5th floor 850 Harrison Ave. Boston, MA
for a follow up	for therapy	to check your INR
617-269-7500	617-414-4238	617-414-2080

Appointment:
Date
Provider
Location
Reason
Phone #

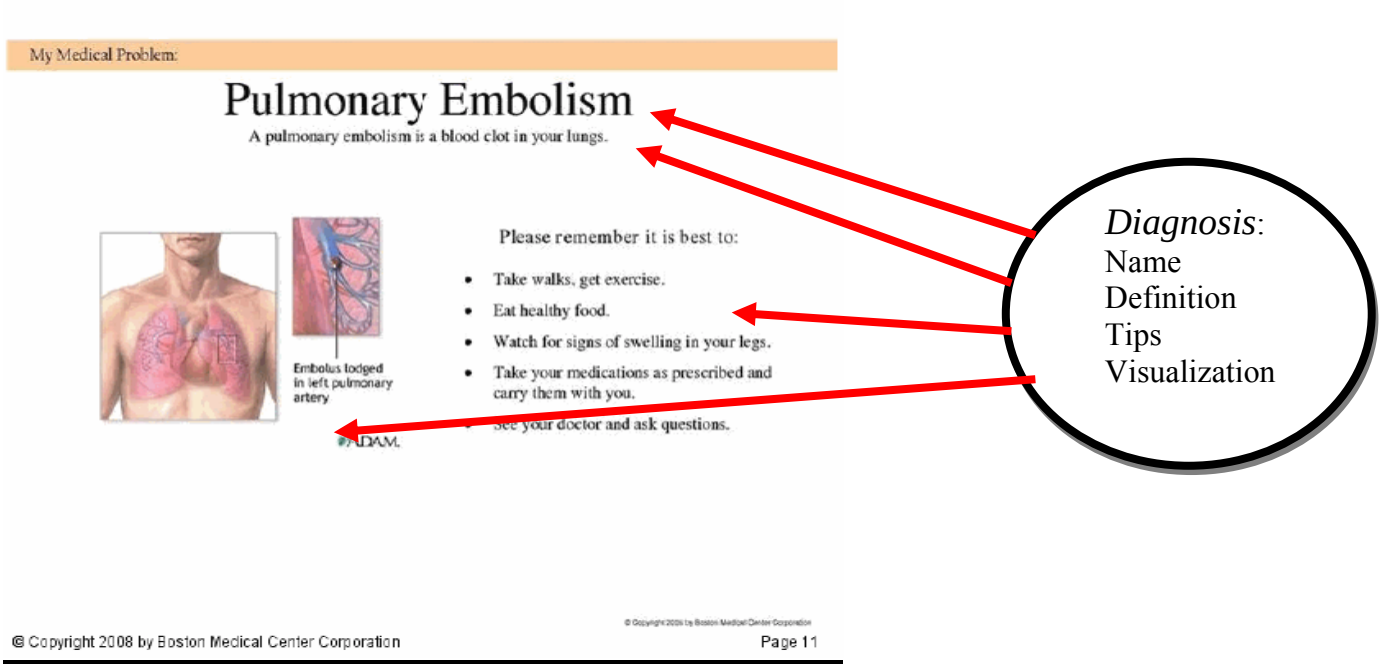
AHCP Example: Appointment calendar

September 2008

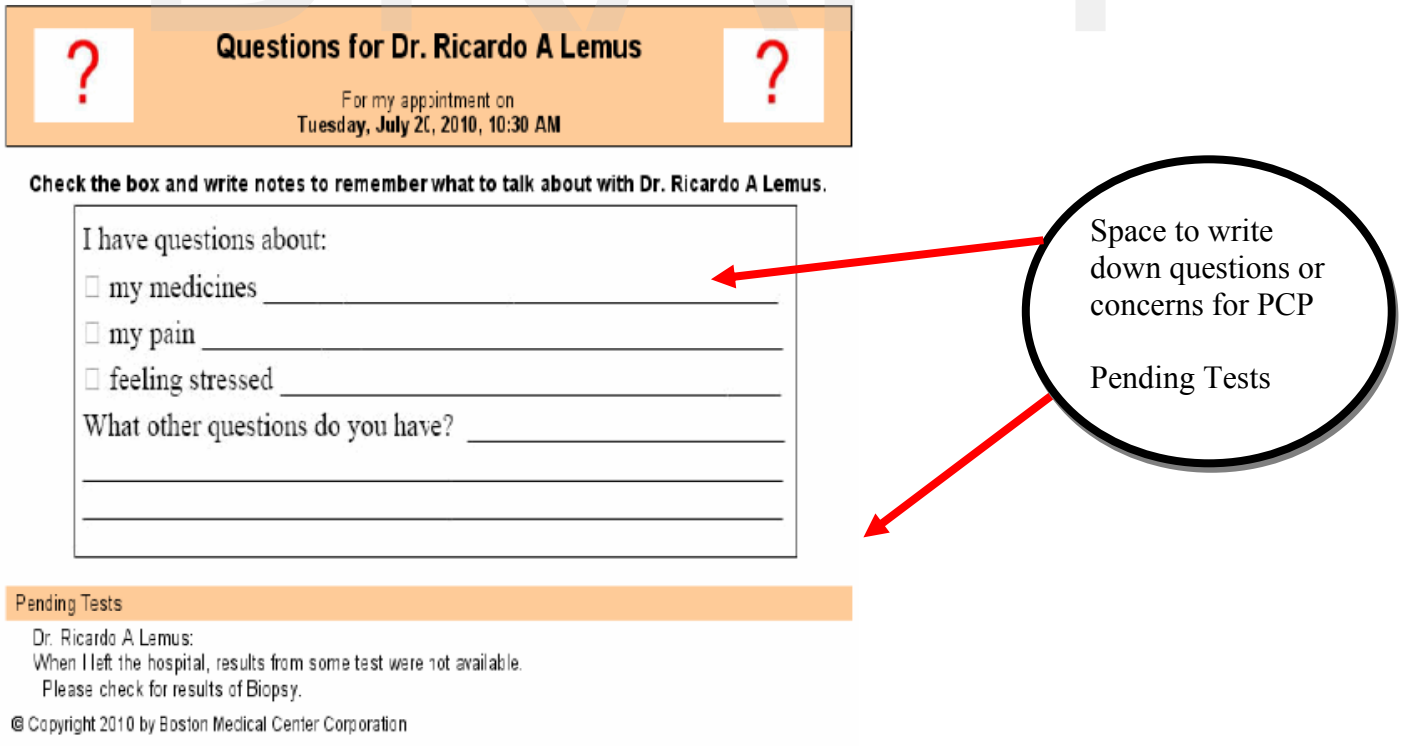
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8 Left Hospital	9	10 Dr. Jack at 2:00 pm	11 Dr. Paascheorlow at 10:00 am	12	13 Coumadin clinic
14	15	16	17	18 Dr. Paascheorlow at 10:00 am	19	20
21	22	23	24	25 Dr. Paascheorlow at 10:00 am	26	27
28	29	30				

Color coordinated (with upcoming holidays noted)

AHCP Example: Diagnosis Information



AHCP Example: Patient Activation Page



APPENDIX B

Example After Hospital Care Plan (AHCP)

** Bring this Plan to ALL Appointments**

After Hospital Care Plan for:

Oscar Sanchez

Discharge Date: October 20, 2006

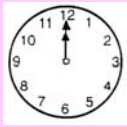
Question or Problem about this Packet? Call your Discharge Educator: (617) 444-1111

Serious health problem? Call Dr. Brian Jack: (617) 444-2222

EACH DAY follow this schedule:

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many (or how much) do I take?	How do I take this medicine?
 Morning	Blood pressure	PROCARDIA XL NIFEDIPINE 90 mg	1 pill	By mouth
	Blood pressure	HYDROCHLOROTHIAZIDE 25 mg	1 pill	By mouth
	Blood pressure	CLONIDINE HCl 0.1 mg	3 pills	By mouth
	cholesterol	LIPITOR ATORVASTATIN CALCIUM 20 mg	1 pill	By mouth
	stomach	PROTONIX PANTOPRAZOLE SODIUM 40 mg	1 pill	By mouth

 Morning	heart	ASPIRIN EC 325 mg	1 pill	By mouth
	To stop smoking	NICOTINE 14 mg/24 hr	1 patch	On skin
	Then, after 4 weeks use →	NICOTINE 7 mg/24 hr	1 patch	On skin
	Blood pressure	COZAAR LOSARTAN POTASSIUM 50 mg	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5 % soln	1 drop	In your left eye
 Noon	Blood pressure	ATENOLOL 75 mg	1 pill	By mouth
	Blood pressure	LISINOPRIL 40 m	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5 % soln	1 drop	In your left eye

 Evening	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5 % soln	1 drop	In your left eye
 Bedtime	Blood pressure	CLONIDINE HCl 0.1 mg	3 pills	By mouth
If you need it for headache	headache	TRAMADOL HCl 50 mg	1-2 pills Every 6 hours If you need it	By mouth
If you need it for chest pain	Chest pain	NITROGLYCERIN 0.4 mg	1 pill every 5 minutes (if need more than 3 pills, call 911)	Under your tongue
If you need it to stop smoking	To stop smoking	NICORELIEF NICOTINE POLACRILEX 4 mg gum	Gum	chew
If you need it for headaches	headache	PERCOCET OXYCODONE-ACETAMINOPHEN 5-325 mg	1 pill 3 times each day If you need it	By mouth

** Bring this Plan to ALL Appointments**

Oscar Sanchez

What is my main medical problem?

Chest Pain

When are my appointments?

Tuesday, October 24th at 11:30 am	Thursday, October 26th at 3:20 pm	Wednesday November 1st at 9:00 am
Dr. Brian Jack Primary Care Physician (Doctor)	Dr. Jones Rheumatologist	Dr. Smith Cardiologist
at Boston Medical Center ACC – 2nd floor	at Boston Medical Center Doctor's Office Building 4th floor	at Boston Medical Center Doctor's Office Building 4th floor
For a Follow-up appointment	For your arthritis	to check your heart
Office Phone #: (617) 444-2222	Office Phone #: (617) 444-7777	Office Phone #: (617) 555-1234

What exercises are good for me?

Walk for at least 20 minutes each day.

What should I eat?

Eating food that is low in fat and low in cholesterol will help you stay healthy.

What are my medication allergies?

REMEMBER you are ALLERGIC to MOTRIN.

Where is my pharmacy?

CVS Pharmacy
1500 Lincoln Ave.
Boston, MA 02121
(617) 555-8888

TRY TO QUIT SMOKING: call Janet Nakamura at (617) 444-8888 at Boston Medical Center

Questions for

Dr. Jack

For my appointment on

Tuesday, October 24th at 11:30 am

Check the box and write notes to remember what to talk about with Dr. Jack

I have questions about:

☐ my medicines _____

☐ my pain _____

☐ feeling stressed _____

What other questions do you have? _____

_____

_____

_____

Dr Jack: When I left the hospital, results from some tests were not available. Please check for results of these tests.

October 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	**2**	**3**	**4**	**5**	**6**	**7**
8	**9**	**10**	**11**	**12**	**13**	**14**
15	**16**	**17**	**18**	**19**	**20** Left hospital	**21**
22	**23** Boston Medical Center will call today or tomorrow	**24** Dr. Jack at 11:30 am at Boston Medical Center ACC – 2nd floor	**25**	**26** Dr. Jones at 3:20 pm at Boston Medical Center Doctor's Office Building – 4th floor	**27**	**28**
29	**30**	**31**				

November 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 Dr. Smith at 9:00 am at Boston Medical Center Doctor's Office Building – 4th floor	**2**	**3**	**4**
5	**6**	**7**	**8**	**9**	**10**	**11**
12	**13**	**14**	**15**	**16**	**17**	**18**
19	**20**	**21**	**22**	**23**	**24**	**25**
26	**27**	**28**	**29**	**30**		

Noncardiac Chest Pain

Noncardiac chest pain is pain that is not caused by a heart problem.

- If your chest pain gets different or worse, call your doctor.
- Take your medications as prescribed.
- See your doctor and ask questions.

Hypertension

Hypertension means high blood pressure.

- Avoid salty foods.
- Take your medications as prescribed.
- See your doctor and ask questions.

Source: National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

Appendix C

Template for manual creation of the AHCP for English or non-English speaking patients

** Bring this Plan to ALL Appointments**

After Hospital Care Plan for: [patient name]

Discharge Date: [discharge date]

Question or problem about this packet? Call your Discharge Educator: (xxx) xxx-xxxx

Serious health problem or concern? Call Dr. [name]: (xxx) xxx-xxxx

PCP Picture HERE

DA Picture HERE

EACH DAY follow this schedule:

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
 Morning				

 Morning				
 Noon				
 Evening				

 Bedtime				
Only If you need it for				
Only If you need it for				

** Bring this Plan to ALL Appointments**

[Insert Patient Name]

What is my main medical problem?

[Insert Primary diagnosis]

When are my appointments?

Date/time of appt		
Provider name		
Provider site information		
Reason for appt		
Provider phone number		

What exercises are good for me?

Default (if applicable):
[Walking is a very healthy form of exercise. Please do your best to walk for at least 20 minutes every day.]

What should I eat?

Default (if applicable):
[Eating food that is low in fat and low in cholesterol will help you stay healthy.]

What are my medication allergies?

REMEMBER you are allergic to [list medicine allergies].

Where is my pharmacy?

[Insert pharmacy name, location, contact information]

{If applicable, include:}

TRY TO QUIT SMOKING: call [contact information]

Questions / Concerns

For my appointment with
[PCP Name]

Check the box and write notes to remember what to talk about with Dr. [PCP name]

I have questions about:

☐ my medicines _____

☐ my pain _____

☐ feeling stressed _____

What other questions do you have? _____

_____

_____

_____

Dr [PCP Name]:
When I left the hospital, results from some tests were not available. Please check for results of these tests:
[List tests done]

Appendix D

RED Preparation Workbook

Patient Name _____ **MRN** _____ **DOB** _____

Family Member/Caregiver Name _____

Room # _____

Date of admission _____

Language Preference_____

Other family/ support contacts?_____

MEDICAL TEAM _____

Attending: _____ Pager # _____ Case Manager :_____ Pager # _____

_____ Pager # _____ Language Services: _____Pager # _____

_____ Pager # _____ Family worker:_____ Pager # _____

Pages to Team:

Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N
Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N
Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N
Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N	Pager: _____ Time: _____ C/B?: Y N

DE Time: (Record time spent in subject's room)

Date: _____ DE: ____ Total: _____	Date: _____ DE: ____ Total: _____	Date: _____ DE: ____ Total: _____
Date: _____ DE: ____ Total: _____	Date: _____ DE: ____ Total: _____	Date: _____ DE: ____ Total: _____
Date: _____ DE: ____ Total: _____	Date: _____ DE: ____ Total: _____	Date: _____ DE: ____ Total: _____

Floor Nurse: (Name of pts. Nurse)

Date: _____ Nurse: _____	Date: _____ Nurse: _____	Date: _____ Nurse: _____
Date: _____ Nurse: _____	Date: _____ Nurse: _____	Date: _____ Nurse: _____

Contacts with family/ caregiver

Date: _____ Name: _____	Date: _____ Name: _____	Date: _____ Name: _____
Date: _____ Name: _____	Date: _____ Name: _____	Date: _____ Name: _____

Date	Outstanding Patient Teaching/Information	Date Addressed

1. Diagnoses

Admitting Dx: _____

Co-morbidities:_____

Discharge Dxs	

2. Follow Up PCP Appointment

____ **Subject has PCP?** If NO, Preferences (gender, location)? _____

Patient requests for PCP appt (weekdays, time of day)**:** _____

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Provider	**Location (Building, floor)**	

Office FAX number: _____

Does subject have transportation to PCP appt? Yes

___**No** ____ Transportation options discussed.

Team appt. requests: _____

Additional Appointments, Tests, or Lab Work to be done POST DISCHARGE

******Attach Additional Appointment Sheet if Needed******

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Provider	**Location (Building, floor)**	

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Provider	**Location (Building, floor)**	

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Provider	**Location (Building, floor)**	

3. Medication Allergies **No Known Allergies _____**

Allergy	Patient Confirm	Allergy	Patient Confirm	Allergy	Patient Confirm

4. Pharmacy

Uses Hospital pharmacy? No ____ Yes ____

Community Pharmacy Name	Phone #, Street address, City

Pt. plan to pick up meds upon d/c: _____

Pt. requests pill box? No ____ Yes ____ (Pill box given ____)

5. Diet

Discharge diet	

Pt. needs diet info. _____

6. Substance use

Substance	SCM	Subject Report	Current Tx. or Interested in Cessation Info?
Alcohol			
Tobacco			

7. Durable Medical Equipment needed at home?: No ____ Yes ____

If pt. checks blood sugar with glucometer, how many times daily? _____

New durable medical equipment ordered: No ____ Yes ____

Type _____

Company name: _____ Contact: _____

Address: _____ Phone: _____

Type _____

Company name: _____ Contact: _____

Address: _____ Phone: _____

8. Current or New Outpatient Services (ex. VNA, PT)? _____

Service _____

Company name: _____ Contact: _____

Address: _____ Phone: _____

Service _____

Company name: _____ Contact: _____

Address: _____ Phone: _____

9. Outstanding Labs/Tests

Labs / Tests Pending	Date Conducted	Results expected	Who will follow up the result

Final Teaching Completed? Yes Done by: DE _____ Other _____

Medicines reconciled with team prior to final teaching? Yes No _____

AHCP given and reviewed by DE with patient? Yes - time spent: _____minutes DE____

If AHCP not given to patient date mailed: _____

Pt. called by DE to review AHCP? Yes – date: _____ DE _____

Family informed

Communication / Notes

Additional Appointments

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Provider	**Location (Building, floor)**	

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