**SAFEMED Discharge Checklist**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIN:\_\_\_\_\_\_\_\_\_\_\_ MRN:\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Instructions: SAFEMED discharge processes should be initiated following enrollment and within 24 hours of admission. Fidelity to discharge processes will be documented via the discharge checklist in the SAFEMED database. Documentation of care processes will be initiated prior to discharge but may be completed and updated in the SAFEMED database post-discharge. In addition, all outpatient referrals and care coordination contacts made to address patient needs should be documented separately in the SAFEMED database under referral and care coordination screens. All clinical documentation of discharge should be entered into the Cerner electronic medical record.**

***I. Care Coordination.*** (APN) *Refer to screening and intake information.*

1. Patient has regular source of primary care. Yes No

*If no, identify primary care provider prior to discharge.*

*If yes,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Alert primary care provider of hospitalization * Schedule outpatient follow up visit * Send SAFEMED discharge note to PCP\* * Coordinate care with PCP | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  hh:mm am/pm  mm/dd/yyyy |

\***Includes template completed within Cerner and faxed to PCP if not MLH-credentialed.**

2. Patient has reliable transportation to provider appointments. Yes No

*If yes, follow up visit date has been coordinated with transportation provider.*  Yes No

*If no,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Assess insurance to determine transportation options * Complete applications/phone calls for transportation service * Coach patient on how to use transportation service * Skill complete when patient uses service successfully | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

3. Patient has identified carer and/or has adequate social support. Yes No

*If no,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Assess options for social support (Senior Companion, homemaker services, adult day care, respite) * Assist patient/carer with applications/phone calls for support services * Encourage participation in local senior center, social or volunteer activities. * Other | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

4. Patient has history of mental illness. Yes No

*If yes,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Alert mental health provider of hospitalization * Schedule outpatient follow up visit * Send SAFEMED discharge note to provider * Coordinate care with outpatient case management and/or mental health provider. | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

5. Patient screens positive (=>5) for depression/anxiety. Yes No

*If yes and score is 5 to 9, brief counseling intervention completed prior to discharge.*  Yes No

*If yes and score is between 10 and 20 (15 GAD-7) ,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Referral to counseling * Referral/Coordination of Psychiatric Care * Assess caregiver stress * Provide information on patient/caregiver support groups * Other . | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

6. Patient screens positive (=>8) for substance misuse/dependency. Yes No

*If yes and score is 8 to 12, brief counseling intervention completed prior to discharge.*  Yes No

*If yes and score is => 13 for women or 15 for men,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Assess patient awareness of negative impacts on health, relationships, job, legal * Assess readiness for change * Discuss community-based supportive services * Make referral * Follow up on patient progress | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

7. Patient has limited mobility. Yes No

*If yes and (B-D) on Addition Risk Factor screening Q.5,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Assess environmental needs (e.g., wheel chair ramps, grab bars, fall risk) * Review GRACE protocol with PCP * Provide Home Safety Checklist to carer/outreach workers (Additional/2nd Home Visit) * Review appropriate care recommendations * Assist in obtaining needed services and equipment * Follow up patient progress | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

8. Patient has low literacy levels. Yes No

*If yes,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Provide low-literacy disease toolkit materials * Other . | mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy |

9. Patient has restricted food access. Yes No

*If yes,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Assess options for food access (SNAP, Meals on Wheels-home/congregate site, LINC 211) * Assist patient/carer with applications/phone calls for food services * Nutrition counseling with caregiver. * Other . | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

10. Patient needs or has difficulty with durable medical equipment use. Yes No

*If yes,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Durable medical needs assessment complete * Patient/carer education & instruction on use * Coordination with hospital case management * Coordination with home health * Other . | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

11. Does patient have additional/persistent unmet social or clinical needs that may contribute to readmission? Yes No

*If yes, what:* .

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Request medical social work order (if home health) * Request inpatient case management social work follow up (if no home health) * Consult SAFEMED Community Advisory Board * Other . | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

***II. Medication Management.***  (CHP)

Intake Pharmacy Assessment Date Completed: mm/dd/yyyy

1. Additional prescription medication(s) were identified during the intake pharmacy assessment that was **not** on the Med Recon Admission Report. Yes No

*If yes, primary reason meds were not reported at admission*

Patient was instructed by a practitioner to stop taking medication

Patient failed to recall medication but is taking

Patient could not afford to fill all prescribed medications

Patient decision not to take med for reasons other than cost

Other, what?

Comprehensive Medication ReviewDate Completed: mm/dd/yyyy

2. Drug therapy problems were identified during the comprehensive medication review. Yes No

*If yes, how many?*

Patient/carer informed of risk, alternatives, and resolution status for all identified drug therapy problems.

Yes No

Prescribing physician and/or attending alerted to any drug therapy problems. Yes No

Did any identified DTPs result in a serious adverse event? Yes No

Did any identified DTPs reach the patient and result in potential for harm but did not cause harm?

Yes No

Did any identified DTPs reach the patient and either lead to harm or require an increase in monitoring?

Yes No

Patient/Caregiver Medication Education Date Completed: mm/dd/yyyy

3. Patient friendly medication list was reviewed with patient/caregiver prior to discharge. Yes No

Purpose of each medication was explained to patient/caregiver. Yes No

Dosing instructions were reviewed with patient/caregiver. Yes No

Potential adverse side effects were reviewed with patient/caregiver. Yes No

Caregiver was present during medication education. Yes No

Date patient friendly medication list was given : mm/dd/yyyy

Final Medication Reconciliation Date Completed: mm/dd/yyyy

4. Medications discontinued at hospital readmission and indicated for post-discharge use are on discharge medication list. Yes No

*If no, why?*

5. The discharge medication list matches the patient-friendly medication list. Yes No

*If no, medication discrepancy is resolved prior to home visit.*  Yes No

6. A plan for getting all needed medications filled exists prior to discharge. Yes No

*If no,*

|  |  |  |
| --- | --- | --- |
| Action Steps: | Date Initiated | Date Completed |
| * Assess options for getting prescriptions to pharmacy * Assess options for picking up prescriptions from pharmacy * Coach patient on obtaining prescriptions within 24 hours of discharge. * Skill complete when patient has all medications on patient-friendly medication list at home. | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy | mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy |

***III. Other***

Symptom Triage Education Date Completed: mm/dd/yyyy

1. Patient received self-management toolkit for driving diagnosis. Yes No

*If no, why?*

2. Signs and symptoms of condition escalation and who to call have been reviewed with patient/caregiver. Yes No

*If no, why?*

3. Patient received education on self-care recommendations for management of condition.

Yes No

*If no, why?*

Home Visit Scheduling Date Completed: mm/dd/yyyy

1. Home visit has been scheduled prior to discharge. Yes No

*If no, why?*

2. Location of home visit has been verified. Yes No

3. Designated carer availability during home visit was determined prior to discharge? Yes No

*If no, designated carer has been informed of home visit date and time.*  Yes No