Re-Engineered Discharge for Skilled Nursing Facilities Checklist

~ Please complete one copy for each patient ~

	Admission Assessment	Initials
Assess Needs: Ascertain need for and obtain language assistance	❑ Determine patient and caregivers' language proficiencies. ❑ Find out about preferred languages for oral communication, phone calls, and written materials. ❑ Arrange for language assistance as needed, including translation of written materials.	
Connect to community services and support	❑ Contact local Aging Service Access Point (ASAP) to connect patient to long term services and support. For example, list of local Massachusetts ASAP's available at https://800ageinfo.com . ❑ Contact VNA to establish any necessary short term home care services. ❑ Find out if patient already has any durable medical equipment (DME) at home. ❑ Use ASAP and VNA Referral Workflow to establish services.	
Identify primary caregiver(s)	❑ Identify the primary caregiver(s). ❑ Assess the primary caregiver(s) needs in order to develop a realistic plan for the next stage of care for the patient. ❑ Integrate the primary caregiver(s) needs into the After Nursing Home Care Plan (ACP). ❑ Share primary caregiver(s) information with the next setting of care. ❑ Provide telephone reinforcement of the ACP. ❑ Prior to patient's discharge, determine if patient or caregiver(s) will be point of contact for follow-up calls.	

	Prepare for Discharge	Initials
Make appointments for follow-up care (e.g., medical appointments and post discharge tests/labs).	❑ Determine patient and caregivers' language proficiencies. ❑ Find out about preferred languages for oral communication, phone calls, and written materials. ❑ Arrange for language assistance as needed, including translation of written materials. ❑ Determine primary care and specialty follow-up needs. ❑ Identify providers (if patient does not have) based on patient preferences: gender, location, specialty, health plan, etc. ❑ Determine need for scheduling future tests. ❑ Make appointments with input from the patient and/or caregiver regarding the best time and date for the appointments. ❑ Instruct patient and/or caregiver in any preparation required for future tests and confirm understanding. ❑ Discuss importance of clinician appointments and tests/labs. ❑ Inquire about traditional healers and ensure that traditional healing and conventional medicine are complementary. ❑ Confirm that the patient and/or caregiver knows where to go and has a plan about how to get to appointments; review transportation options and address other barriers to keeping appointments.	
Identify the correct medicines and a plan for the patient to obtain them.	❑ Ascertain what vitamins, herbal medicines, or other dietary supplements the patient takes. ❑ Review all medicine lists with the patient and/or caregiver, including, when possible, the nursing home medicine list, as well as what the patient reports taking. ❑ Identify a plan to ensure medicines are available until PCP apt.	
Plan for the follow-up for tests or labs that are pending at discharge.	❑ Identify tests and lab work with pending results. ❑ Discuss who will review the results and when and how the patient and/or caregiver will receive this information.	

	Prepare for Discharge	Initials
Organize post discharge outpatient services and durable medical equipment (DME).	❑ Collaborate with the care team to ensure that DME is obtained. ❑ Document all contact information for medical equipment companies, home health services, and ASAPs on the ACP 7-10 days prior to discharge. ❑ Collaborate with the care team to arrange necessary at-home services, including required documentation and MD signature for homebound status and face to face visit.	
	Prepare for Discharge - Teach	**Initials**
Educate the patient about his or her diagnosis and medicines during the patient's stay.	❑ Provide education on primary diagnosis and comorbidities. ❑ Explain what medicines to take, emphasizing any changes in the regimen. ❑ Review each medicine's purpose, how to take each medicine correctly, and note important side effects. ❑ Confirm that patient has enough medicines to get to next appointment and/or the ability to obtain them (transport, assistance). ❑ Address patient's and/or caregiver's concerns about the medicine plan.	
Teach a written discharge plan the patient and/or caregiver can understand.	❑ Research the patient's medical history and current condition. ❑ Communicate with the inpatient team regarding ongoing plans for discharge. ❑ Create an ACP, the easy-to-understand discharge care plan. ❑ Review and orient the patient and caregiver to all aspects of the ACP. ❑ Use the teach-back method to validate understanding.	
Review with the patient and/or caregiver what to do if a problem arises.	❑ Explain to patient/caregiver that they can expect a follow-up phone call after discharge to ensure all services are in place and to answer any questions. ❑ Show when & how to contact providers following discharge – provide numbers and plan for regular and off-hours (e.g., evenings/ weekends). ❑ Instruct on what constitutes an emergency and what to do in cases of emergency and nonemergency situations.	

	Discharge Plan Review	Initials
Assess the degree of the patient/caregiver's understanding of the discharge plan 7-10 days prior to discharge.	❑ Use the teach-back method to assess understanding: Ask patient and caregiver to explain in their own words all aspects of the plan. Have them review plan for: ❑ Medication ❑ Appointments ❑ Labs ❑ Home services ❑ Equipment ❑ What to do if problem arises	
Review discharge plan – any changes upon discharge	❑ Repeat the step above at discharge – highlight any changes	
Provide discharge summary and ACP to receiving clinicians.	❑ Provide discharge summary and ACP to receiving clinicians (e.g., PCP, Specialist and Home Health) within 24 hours of discharge. ❑ Provide ACP to patient and/or caregiver at discharge.	
	Post Discharge Follow-Up	**Initials**
Provide telephone reinforcement of the discharge plan within 2 business days after discharge from the SNF.	❑ Reinforce the ACP. ❑ Use provided check-list to verify that all services are in place, according to the plan. ❑ Answer phone calls from patients, family, and other caregivers with questions about ACP, nursing home stay, and follow-up plan to help patient transition from nursing home care to outpatient care setting. ❑ Assist with problem solving.	
Provide telephone reinforcement of the discharge plan 30 days after discharge from the SNF.	❑ Use provided check-list to verify discharge plan ❑ Answer phone calls from patients, family, and other caregivers with questions about the ACP, nursing home stay, and follow-up plan in order to help patient transition from nursing home care to outpatient care setting.	

[1] Agency for Healthcare Research and Quality, RE-Engineered Discharge (RED) Tool Kit: https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html