Tool 3: How To Deliver the Re-Engineered Discharge at Your Hospital

24. 1. Purpose of This Tool

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

Know the procedures for delivering each component of the RED (except the postdischarge followup phone call), including how to create and teach the After Hospital Care Plan (AHCP).

Possess communication and educational competencies required for an effective discharge. For additional techniques on delivering the RED to diverse populations, see Tool 4, "How To Deliver the Re-Engineered Discharge To Diverse Populations."

25. 2. Role of the Discharge Educator

The goal of the DE is to educate and advocate for patients in order to best prepare them and their caregivers for discharge and success following discharge from the hospital. DEs are charged with making sure the elements of the RED are followed. The DE collaborates with the patients' multidisciplinary medical teams about what happens during the hospital stay and what needs to be done for a safe transition home.

The DE works with medical teams and other hospital staff (e.g., social worker, case manager, discharge planner) to:

Review the discharge plan that has been developed by the medical team and identify service gaps.

Address gaps by arranging for appropriate services (e.g., diabetic education, visiting nurse).

Identify barriers to the discharge plan and strategies to overcome these barriers (e.g., transportation issues, cost of medicine, anticipated medicine side effects).

Create the AHCP, an easy-to-understand discharge plan, and teach it in a way that enables patients to understand how to care for themselves once they go home.

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, except for the postdischarge followup phone call. (See Tool 5, "How To Conduct a Postdischarge Followup Phone Call.") At your hospital, several staff members may perform RED responsibilities, and the DE may make the followup phone call. For a discussion of these options, see Step 7: Determine How To Train Discharge Educators and Followup Callers in Tool 2, "How To Begin the Re-Engineered Discharge Implementation at Your Hospital."

In the clinical trial of the RED, the RED consisted of 11 mutually reinforcing components that are delivered throughout the hospitalization and shortly after discharge. However, only English-speaking patients participated in the trial. To serve diverse populations, including speakers of languages other than English, hospitals will have to provide language assistance. We have therefore added a component on language assistance to the RED. Table 1 below summarizes the 12 components of the RED and actions the DE takes to implement these components.

Table 1. RED Components and Discharge Educator Responsibilities

RED Component	DE Responsibilities
1. Ascertain need for and obtain language assistance.	Find out about preferred languages for oral communication, phone calls, and written materials. Determine patient and caregivers' English proficiency Arrange for language assistance as needed, including translation of written materials.
2. Make appointments for followup care (e.g., medical appointments and postdischarge tests/labs).	Determine primary care and specialty followup needs. Find providers (if patient does not have) based on patient preferences: gender, location, specialty, health plan participation, etc. Determine need for scheduling future tests. Make appointments with input from the patient regarding the best time and date for the appointments. Instruct patient 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 knows where to go and has a plan about how to get to appointments; review transportation options and address other barriers to keeping appointments (e.g., lack of daycare for children).
3. Plan for the followup of results from 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 will receive this information.
4. Organize postdischarge outpatient services and medical equipment.	Collaborate with the case manager to ensure that durable medical equipment is obtained. Document all contact information for medical equipment companies and at-home services in the after hospital discharge plan (AHCP). Assess social support available at home. Collaborate with the medical team and case managers to arrange necessary at-home services.
5. Identify the correct medicines and a plan for the patient to obtain them.	Review all medicine lists with the patient, including, when possible, the inpatient medicine list, the outpatient medicine list, and the outpatient pharmacy list, as well as what the patient reports taking. Ascertain what vitamins, herbal medicines, or other dietary supplements the patient takes. Ensure a realistic plan for obtaining medicines is in place.
6. 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.

RED Component	DE Responsibilities
7. Teach a written discharge plan the patient can understand.	Research the patient's medical history and current condition. Communicate with the inpatient team regarding ongoing plans for discharge. Create an AHCP, the easy-to-understand discharge plan sent home with the patient. Review and orient the patient, family, and caregiver to all aspects of the AHCP. Encourage questions.
8. Educate the patient about his or her diagnosis and medicines.	Provide education on primary diagnosis and comorbidities. Explain what medicines to take, emphasizing any changes in the regimen. Review each medicine's purpose and how to take each medicine correctly, and note important side effects. Assess patient's concerns about medicine plan.
9. Review with the patient what to do if a problem arises.	Instruct on a specific plan of how to contact providers by providing contact numbers, including evenings and weekends. Instruct on what constitutes an emergency and what to do in cases of emergency and nonemergency situations.
10. Assess the degree of the patient's understanding of this plan.	Ask patients to explain in their own words the details of the plan (the teach-back technique). Contact family members and other caregivers who will share in the caregiving responsibilities if necessary.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.	Deliver discharge summary and AHCP to clinicians accepting care of patient (including visiting nurses) within 24 hours of discharge.
12. Provide telephone reinforcement of the discharge plan.	Call the patient within 3 days of discharge to reinforce the discharge plan and help with problem solving. Staff DE help line. Answer phone calls from patients, family, and other caregivers with questions about the AHCP, hospitalization, and followup plan in order to help patient transition from hospital care to outpatient care setting.

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27. 3. The After Hospital Care Plan

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

We call the discharge plan the AHCP, because the patients are often not familiar with the word "discharge." The AHCP is a booklet that presents the information patients need to prepare for the days between discharge and the first visit with the clinician in charge of the patient's outpatient care. While this will frequently be the patient's primary care provider (PCP), sometimes specialists serve this role. In this toolkit we use the term PCP to refer to the clinician who has main responsibility for the patient.

The AHCP is designed to be easily understood, even for patients or caregivers with limited health literacy. The AHCP is finalized, printed, and used as a teaching aid by 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 reviews each part of the AHCP with patients and confirms that they understand what to do when they go home.

The AHCP may be bound with a spiral plastic binder. Patients can be given a magnet with your hospital logo so that they can take it home and hang it on the refrigerator. Then they can open to the color-coded calendar of the next 30 days of events or whatever page is most important to them.

See Appendix A, "Components of After Hospital Care Plan," for visual examples of these components, which are summarized in the next section.

28.3.1. 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 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 medicine allergies.

A list of upcoming appointments with clinicians, including visiting nurses, tests, etc., for the next 30 days. This includes location of appointments and numbers to call if the patient needs to reschedule.

A 30-day calendar that is color coordinated to the appointments. The calendar also indicates what day to expect a followup phone call, and observed cultural and religious holidays to trigger the DE and the patient to consider upcoming events that may affect the keeping of appointments.

A diagnosis information page.

A patient activation page for the patient to record questions, concerns, and symptoms to be discussed at the followup clinician appointment.

A list of outstanding test results (when applicable).

A list of durable medical equipment the patient has or needs to obtain or have delivered to his or her home (when applicable). This includes contact information of the company providing equipment, when it will be delivered, and whom to call if the equipment is not delivered or if there are malfunctions.

The patient's advanced directives for his or her end-of-life care.

Recommendations for diet modifications (when applicable).

Recommendations for exercise or physical activity limitations (when applicable).

See Appendix B for an example of an AHCP.

29.3.2. 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 information that is needed to produce an AHCP and complete a RED discharge.

The RED Workstation is a software program that allows the DE to enter all the information that has been collected in the Workbook. You can also upload photographs of the patient's DE and PCP (if you have one) to print on the front cover of the AHCP. Using the Workbook, the DE can enter the RED components into the Workstation as the DE gathers information throughout the patient's hospitalization (e.g., appointments, medicines, diagnosis).

Some of the information can be imported into the Workstation directly from the electronic health record (EHR), therefore eliminating some of the manual entry. Once the information is entered, it is designed to automatically print a personalized AHCP. If your hospital is not using the Workstation, the DE may use the Workbook to generate an AHCP using a template.

Appendix C is the template for creating the AHCP for English-speaking patients and Appendix D is the template for Spanish-speaking patients. Tool 2, "How To Begin the Re-Engineered Discharge Implementation at Your Hospital," reviews the options for generating the AHCP. Appendix E contains a copy of the Workbook.

30. 4. Steps To Deliver the RED

The following sections provide step-by-step guidance for the DE describing how to perform the RED. For the remainder of this tool, we address the DE directly. There are also examples and tips on how to retrieve, document, and teach the RED components.

31.4.1. 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 delivered in the hospital so far, and the treatment plan. This information is generally in the admission history and physical section of the chart, in the daily progress notes, and in any consultation notes. This information includes:

Patient's age, birth date, sex, inpatient doctor's name, and admission date.

Patient's language preferences for oral communication, phone calls, and written materials and need for an interpreter and translated materials.

Patient's self-described cultural/racial/ethnic background.

Diagnoses (admitting diagnosis and comorbidities) and functional status.

Medicine list (including herbal or natural supplements and other traditional medicine).

Medicine allergies.

Sensory deficits.

Any equipment used or needed at home.

Test results and completed tests with pending results.

Advanced directives or health proxy.

Medical team's discharge plan.

Unless your RED Workstation is programmed to enter this information automatically, enter information into the RED Workbook. For example, diagnosis information is recorded in the Workbook as shown below.

Diagnoses

Admitting Dx: *chest pain*
Comorbidities: *hypertension, hypercholesterolemia*
Discharge Dxs: *Chest pain, hypertension, hypercholesterolemia*

32.4.2. Confer With the In-Hospital Medical Team

Before meeting with your patient, be sure to contact the in-hospital medical team with whom you will collaborate 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. The following is a list of items to cover with the medical team:

What is the best way to communicate with the medical team (e.g., pager, email, telephone)?

When is the best time to check in each day?

Can you confirm the diagnosis(es)?

Is the patient aware of his or her diagnosis?

Is it o.k. to discuss the diagnosis, daily plan, discharge plan, and appointments needed directly with the patient?

Can you confirm the medicine 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?

33.4.3. 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 Tool 4, "How To Deliver the RED to Diverse Populations at Your Hospital."

Whenever possible, arrange for caregivers to be present when meeting with the patient or arrange to meet with them separately. It is important to set expectations with patients and their caregivers, to show them that in fact their questions will be answered and that you will take the time to make sure they understand everything they need to know.

If the patient cannot communicate or is not mentally competent to make decisions, you will need to work with the patient's legal proxy. A legal proxy, who may or may not be a caregiver, is the person with legal authority to act on the patient's behalf.

34. 5. First Meeting With the Patient

Throughout the hospital stay, you will educate 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. People generally understand and retain less than 50 percent of information discussed, and communication is even 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 teach them by using the following communication strategies. More information can be found in Tool 4, "How To Deliver the RED to Diverse Populations at Your Hospital."

During the first meeting with the patient, you will introduce the RED and the role of the DE. If language preferences and interpreter needs have been established upon admission, assign the patient to a certified bilingual DE, or arrange for interpreter services for all meetings with the patient. Tips for the first meeting include the following:

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 or she prefers to be addressed.

If not already established, ask about language preferences for oral communication, phone communication, and written materials.

Assess and meet patient's language assistance needs. If the patient is not proficient in English, and you are not certified bilingual in the patient's preferred language for oral communication, obtain interpreter services. Patients can be ashamed that they do not speak English very well and may claim to understand and say they do not need interpreter services even when they do not understand. Other times patients say that a friend or relative can intepret for them. Let the patient

know that it is the hospital's policy to always use a qualified medical interpreter. Do not continue until an interpreter arrives or is connected by telephone.

Assess and meet language assistance needs of the patient's caregivers. Even if the patient is proficient in English, the patient's caregivers may not be. Caregivers' understanding of the discharge plan will be critical to a safe transition home.

More information on language assistance can be found in Tool4, "How To Deliver the RED to Diverse Populations at Your Hospital."

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

Be attuned to body language. When possible, it is advisable to sit.

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."

Speak slowly.

Use plain, nonmedical language.

Listen actively; do not interrupt.

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

35.5.1. Orient the Patient to the RED

It is helpful that the patient and involved caregivers understand your role as the DE and how you will help 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 unnecessarily 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 AHCP and discharge summary will be sent to your primary care provider to help ensure the smooth transfer of care from the hospital doctors to your primary care provider.

Your DE will teach you the important things you need to know about your illness, your medicines, and your followup appointments and what to do if you run into problems after returning home.

Your DE will help answer your questions.

36.5.2. Gather Information From the Patient

Once the patient understands your role as the DE, continue engaging the patient in discussion that will help you to gather and confirm essential details needed to construct the AHCP. The essential information to gather from the patient includes:

PCP's name and office location.

Patient's understanding of illness and treatment.

Medicines taken at home prior to admission.

Patient contact information and preferences for followup phone call. (See Appendix F.)

Names and contact information for the health proxy, caregivers, and social support persons. (See Appendix F.)

Pharmacy name and location.

Medicine allergies.

Advanced directives.

Durable equipment he or she has/should have at home.

Record this information in the Workbook.

You will also want to verify and supplement information collected from the medical record. For example, be sure to discuss diagnosis and other comorbidities with the patient, as there may be additional information to gather from the patient not yet captured in his or 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 comorbid condition rather than their original principal diagnosis.** If, for example, a patient admitted for chest pain also has hypertension, education about the proper monitoring of hypertension may potentially avoid rehospitalization.

37.5.3. Engage in Daily Interactions With the Patient

The goal of the followup patient sessions is to *teach and reinforce* important health and treatment plan information. It also is to identify and address discrepancies between the medical team's discharge plan and the patient's understanding of the discharge plan, as well as barriers to patient understanding. Following the initial meeting, you will make a plan with the patient to return to teach 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.

Which parts of the education can be done safely after discharge.

The postdischarge telephone call can be used to deal with the elements that were not fully covered by the time of discharge. It is important to assess whether the patient or caregivers will want interpreter services for phone calls. Do not assume that because people can speak in English without an interpreter at the hospital they will be able to comfortably complete the phone call in English. A telephone presents another hurdle, as it removes context, body language, and lip movement.

38. 6. 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. The sections below show examples from the Workbook, which correspond to the sample AHCP.

39. 6.1. Make Appointments for Followup and Postdischarge Tests/Labs

Arranging for a postdischarge appointment to follow up on ongoing medical issues is one of the most important components of the RED. The postdischarge appointments include not only clinicians (primary care clinician, 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 of medical equipment delivery, date and times to go to the anticoagulation clinic, etc. All this information is entered into the Workbook 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.

6.1.1. 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 might be assisting with transportation.

Ask the patient about:

Whether any friends or family members will be involved in the appointment or transportation.

Days or times when appointments should *not* be booked, including cultural or religious holidays the patient observes.

Days and times that are particularly good.

Any potential problems keeping appointments.

Transportation options.

Whether an interpreter will be needed. (For more information, see Tool4, "How To Deliver the Re-Engineered Discharge to Diverse Populations.")

Confirm that he or she knows how to reschedule if a conflict arises. You may say something like:

> "I will do my best to make your appointments according to the 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."

If the AHCP is printed using the RED Workstation, then the 30-day calendar automatically lists national and religious holidays or observances. Appointments should be made to avoid these conflicts. Also ensure that there are no conflicts among multiple appointments. After making appointments, verify that your patient, and whoever else will attend the appointment, can make them. Reschedule appointments if it turns out there is a conflict or difficulty obtaining transportation.

Use the information gathered above to complete the corresponding Workbook sections as shown below, adding in information about appointments as they are made.

For appointments with the patient's PCP, complete the Workbook section below.

PCP Name	**Day / Date / Time**
Postdischarge PCP Appointment _*YES*___ **Patient has PCP**? If NO: Preferences (gender, location)? _____ _____ **Patient requests for PCP appt** (weekdays, time of day)**:** ***Wednesday mornings***_____ **Team requests for appointments**: ____***cardiologist and rheumatologist***_____	
Dr. Avery	***Wednesday, August 8th at 11:30***
Clinician to see at appt (if not PCP)	**Location**
	Address/Floor: ***100 Main Street, 2nd floor, Anytown, ST*** **Phone #:** ***617-555-5555*** **Fax #:** ***555-555-2192***
Does patient have transportation to PCP appt? ____ _Yes ___No ____ Transportation options discussed	

For appointments with visiting nurses or a physical, occupational, or speech therapist, complete the Workbook section below to record postdischarge home services.

Service __**Vital signs**_____

Company name: **Visiting Nurse Service of N.E.**____ Contact: **Judy Johnson**_____

Address: **Patient's home**_____ Phone: **555-555-5555**_____

Date scheduled:__**Tuesday August 2nd**_____

If the patient has any outstanding lab tests that need to be completed after discharge, teach the patient or a caregiver about the test and its importance, and arrange scheduling as needed. For tests or lab work or other appointments, use the information gathered above to complete the Workbook sections below.

Day/Date/Time	Phone and Fax #	Reason/Test/Lab
Thursday August 16th 3:20pm	**Ph:*617-555-4124*** **Fax: *617-444-7000***	***Arthritis***
Provider	**Location**	
Dr. Jones	***100 Pleasant Road, Suite 105, Anytown, ST***	

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
Wednesday, September 12th at 9am	**Ph: *617-555-9567*** **Fax: *555-555-5555***	***Heart condition***
Provider	**Location (Building, floor)**	
Dr. Wu	***100 Park Road, Suite 504, Anytown, ST***	

6.1.2. What If the Patient Does Not Have a Primary Care Provider?

If the patient does not have a clinician who takes responsibility for the patient's care (i.e., a PCP), check with the medical team or with hospital administration to learn how new PCPs are assigned at your hospital. Typically, PCP assignment does not require a referral. If your hospital does not have associated community health centers (CHCs), you should attempt to develop relationships with the CHCs and established private practices in the area.

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 or 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 or she has any preferences such as gender or language the PCP speaks. Once a PCP is located, make a followup appointment (preferably in the first week and no later than 2 weeks after discharge) to aid in a safe transition to the ambulatory setting.

40.6.2. Follow Up on Test or Lab Results That Are Pending at Discharge

An important component of the RED is to ensure good followup for tests done in the hospital with results pending at discharge. These pending test results are frequently not followed up, and many of these test results require action.

Find out about pending tests by reviewing the patient's medical chart, checking the hospital laboratory reporting system, and speaking with the medical team. When the information is identified, it can be recorded in the RED Workbook, as shown in the following section:

Outstanding Labs/Tests

Labs/Tests Pending	Date Conducted	Results Expected	Who Will Follow Up on the Result
Stomach biopsy to test for H. pylori	***8/1***	***8/6***	**Dr. Avery (appointment on August 8)**
Angiotensin-converting enzyme	***8/1***	***8/10***	**Dr. Jones (appointment on August 16)**

At discharge, explain to the patient that some test results are still not ready. Point out where these tests are noted in the AHCP. Explain which test/lab results are still pending, who will review the results, and when and how the patient will receive this information. You can say something like this:

> "Remember having [test/lab] done? You will be ready to leave the hospital before the results from [that/those tests/labs] 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]."

41.6.3. Organize Postdischarge Medical Equipment and At- Home Services

Many patients leaving the hospital require medical equipment and services to care for themselves at home. Coordination of equipment and at-home services is necessary to safely transition the patient home. The absence of these services can lead to a return to the ED or hospital.

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 medical team. For example, some patients will need oxygen delivered to the home. Enter into the Workbook 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.

Portable toilet (commode).

Mask and equipment to help sleep (CPAP).

Wheelchair.

Oxygen.

Medicine sprayer (nebulizer).

Tool to measure how deeply you breathe (peak flow meter).

Tool to measure blood sugar (glucometer).

Scale.

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

When reviewing the AHCP, you can discuss the importance of each piece of equipment and how to use it. Whenever 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. Have the patient show you how he or she will use the equipment at home.

42.6.4. Identify the Correct Medicines and a Plan for the Patient To Obtain Them

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

The purpose of medicine reconciliation in preparation for hospital discharge is to determine that the patient's discharge medicine list and discharge summary medicine list reflect the most recent and accurate updates made to the patient's medicine plan. Although the Joint Commission requires medicine reconciliation, many hospitals find it challenging. If your hospital does not have an established medicine reconciliation process, it can use resources such as the MATCH Reconciliation Toolkit (available at: www.ahrq.gov/qual/match/) to develop one. In the meantime, you will need to develop a single, accurate medicine list.

Some tips for discharge medicine reconciliation are:

Obtain the current list of medicines from the outpatient medical record (when available), the inpatient chart, and in some cases, the patient's 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 or she is taking. You might say:

> "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. I'd like you to tell me whether you are currently taking these medicines, and if so how much you take.

After reviewing all the medicines on the list with the patient, you might say:

> "Now I'd like you to tell me if there are any other medicines you are talking that aren't on this list. We may talk to your provider, and even talk to your pharmacy, so that we can make sure everyone has the correct list."

Ask if the patient uses or plans to use any other types of treatments along with the medicines, such as herbs, 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 and alternative medicine specialist or Web resources, such as the National Center for Complementary and Alternative Medicine at 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 medical team and identify what medicines the patients should and should not be taking. Before discharge, resolve all discrepancies discovered in the medicine list.

If your hospital inpatient unit has access to the outpatient EHR, update it with the current medicine list.

Once it is finalized, attach the reconciled list of the medicines to the Workbook and enter it into the Workstation. This should be done as soon as possible because waiting until the day of discharge makes this process error prone.

6.4.1. Identify Problems the Patient Might Have Obtaining Medicine

Explore if the patient might have any problems 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 the following:

"What pharmacy will you use to fill your prescriptions?"

"How will you get to the pharmacy to pick up your medicine - 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?"

"Medicines can be expensive. Have you ever had any trouble paying for your medicines?"

If the patient identifies potential problems picking up medicines, 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 that will deliver medicines and medical supplies. If you cannot 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

Joe's Pharmacy	1234 Summertime Ave, Anytown, ST 55555 (555) 555-7777
Pt. requests pill box? No ____ Yes __ ___ (Pill box given _____)	

If the patient says he or she might have trouble paying for medicines, explore resources to help patients pay for their medicines. For information about overcoming financial barriers to obtaining medicines, see Tool 19 in the *Health Literacy Universal Precautions Toolkit* (available at: www.ahrq.gov/qual/literacy/).

6.4.2. Confirm Medicine Allergies

All medicine allergies are confirmed with the patient, documented in the Workbook, 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. Document allergies in the appropriate section of the Workbook, as shown below.

Documenting Medicine Allergies

Allergies _Y_ No known allergies ____					
Allergy	**Patient Confirm (Y/N)**	**If No, Explain**	**Allergy**	**Patient Confirm (Y/N)**	**If No, Explain**
Motrin	***Y***				

43.6.5 Reconcile the Discharge Plan With National Guidelines

The purpose of the RED and the role of the DE are to teach the discharge plan that has been determined by the medical team. The hospital discharge, however, provides an important opportunity to be sure that the patient is on the optimal treatment plan. Many patients are discharged from U.S. hospitals on treatment regimens that do not follow national recommendations. Therefore, identifying and rectifying these inadequacies is an important component of the RED.

Once the discharge diagnoses are known, the treatment plan should be compared with any relevant national guidelines. We recommend that you refer to the National Guideline Clearinghouse at the Agency for Healthcare Research and Quality (AHRQ) Web site (available at: http://guideline.gov/) as an up-to-date source.

If there are potential discrepancies, you should check to see if the medical team knows of a clear reason for not following the guideline. For example, according to national guidelines patients with coronary artery disease should be on aspirin unless there is a clear documented

contraindication. If such a patient is not on aspirin and there is no clear documentation for a contraindication for aspirin, it is important to contact the medical team to discuss potential modifications to the discharge plan. Either the treatment plan will need to be altered or appropriate documentation will be needed to record the contraindication. Remember, your patient will benefit from these "double checks."

The discussion with the medical team can go something like this:

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

44. 6.6. Teach the Content of a Written Discharge Plan in a Way the Patient Can Understand

Once you gather and enter all the information, first into the Workbook and then into the Workstation or Word template, you will print a final AHCP to give to your patient. If English is not the patient's preferred language for written materials, use the Workstation's capacity to print the AHCP in other languages. If you are not using the Workstation, or your Workstation cannot support the patient's preferred language, arrange for the AHCP to be translated by a qualified translator. (See Tool 4, "How To Deliver the RED to Diverse Populations at Your Hospital.")

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.

IMPORTANT: 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.

6.6.1. Teach About the Patient's Diagnosis

When the AHCP is printed, it will contain educational information about the primary diagnosis and other comorbidities. Whenever possible, provide patient education materials in the language the patient prefers for written materials. The DE should ask the medical team if the patient is aware of his or her diagnosis before discussing the diagnosis with the patient. Be careful of certain cultural contexts when educating the patient about diagnosis and treatment. (See Tool 4, "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 the person's diagnosis or comorbidities, ask the patient about his or her health beliefs. The RED studies show that up to half of patients are not following their discharge plan 2 to 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 health beliefs can assist in treatment plan adherence.

An open-ended question that allows 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 his or her 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 have [symptoms/problem] is that [explain diagnosis in plain language]. This is called [medical diagnosis]. May I tell you more details about your medical problem?"

If yes, give the patient the RED illustrated diagnosis information sheet (see examples in Appendix G) describing his or her specific diagnosis 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 and friends, 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 everyday, nonmedical language. You will also need to confirm comprehension (see Section 6.7.1 for tips). Once you are confident that the patient understands his or her diagnosis, you can move on to the next topic.

6.6.2. 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.

What to do if he or she misses a dose.

The reason he or she is to take them.

Which medicines to continue taking and which to stop taking.

How long to take it (even if symptoms go away).

Potential side effects.

Not to discontinue without calling the doctor (when appropriate).

The importance of bringing all medicines to followup appointments.

See Section 6.7.1 for tips on how to confirm comprehension.

6.6.3. Teach About Appointments

After you have made the patient's followup appointments, review the details with the patient, including:

Appointment date, time, and location.

How the patient will get there; provide maps and directions if needed.

The purpose of the appointment.

Remind your patient:

If for any reason a conflict arises and he or she needs to change an appointment, to call the doctor's office to reschedule.

That the contact information will be located in the AHCP.

To bring the AHCP to all appointments.

That someone from the RED team will call in approximately 48 hours to check in and go over the patient's medicines.

See Section 6.7.1 for tips on how to confirm comprehension.

6.6.4. Encourage Questions

Patients can feel ashamed to ask questions and often are not even sure what questions they need to ask. Here are some tips for encouraging questions during your sessions with the patient:

Do not appear to be in a hurry. Patients often do not ask questions because they think the hospital staff are too busy to take the time to answer questions.

Communicate that you expect questions. For example, you could say, "That was a lot of information. I'm sure you must have questions."

Listen and do not interrupt. Questions will often emerge if you let patients talk.

Do not just ask, "Do you have any questions?" Patients often say no even if they do have questions.

Invite family members and caregivers to ask questions.

Ask Me 3 was developed to help promote effective communication between patients and providers in an effort to improve patient understanding. This technique can be helpful in teaching

the AHCP. The program encourages patients to ask about three things before leaving the medical encounter:

45. What is my main problem?

46. What do I need to do?

47. Why is it important for me to do this?

More information is available at: www.innovations.ahrq.gov/content.aspx?id=163.

The patient should also be encouraged to ask as many questions as he or 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 health care by customizing lists of questions about starting new medicines, surgery, or medical tests. Building a list of personalized questions can empower patients to ask the questions that will elicit the information needed to make informed decisions. More information is available at: www.ahrq.gov/questionsaretheanswer/index.html.

You also need to encourage your patients to ask questions of the providers they see after they leave the hospital. To address this need, the AHCP contains a page that helps guide the patient to prepare for his or 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 and help the patient start to write his or her questions on this page. Family members can contribute to this page as well, as they too may have questions, concerns, or observations of their own.

48.6.7. Assess the Degree of Patient Understanding

When asked, "Do you understand," patients will frequently say, "Yes," whether or not they understand. 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 cannot understand, then someone needs to assist them at home or another plan needs to be implemented. To ascertain when a patient understands what you have taught, use the "teach-back" method, an evidence-based communication strategy described below.

6.7.1. 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 or she needs to know in a manner that the patient understands. Patient understanding is confirmed when he or she explains the information back to you in his or her own words. Lack of understanding and errors can then be rectified with further directed teaching and reevaluation of comprehension.

A video demonstration of the teach-back method is available at: 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 concepts.

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, clarify the information that you presented and allow the patient to teach back again. Do this until the patient is able to correctly describe your directions in his or her own words.

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

The Diagnosis: "I want to make sure I explained things clearly. Please tell me how you would describe your illness?"

The Medicines: "Medicines can be very complicated; I need to make sure I've explained everything. Please show me how you will take your [ask about a specific medicine] when you get home?"

The Appointments: "O.k., tell me where and when your first doctor's appointment will be."

Remind patients that all the information they need to know is in the AHCP. This is not a memory test; 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. After several rounds of teach-back, if the patient still has trouble the medical team should be notified and an alternative plan should be created.

6.7.2. What If My Patient Cannot Understand the Discharge Plan?

Patients who cannot 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 or she returns home. In this situation, you can ask the patient if there is any person he or she would like to be informed of the discharge plan. When someone is identified, arrangements should be made to orient the caregiver to the AHCP. Have the caregiver present during teaching sessions and confirm the caregiver's understanding with teach-back.

In keeping with Health Insurance Portability and Accountability Act requirements, remember to obtain the patient's written permission to share health information with an identified caregiver and ascertain if the caregiver should receive the followup call in lieu of the patient.

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 a social worker might be particularly important. Social workers can assist with assessment and potential intervention, in an effort to improve communication with and support for the family and to organize a safe discharge.

If a reliable caregiver is not identified, it may be appropriate to arrange for a visiting nurse service or a higher level of community care if necessary.

49.6.8. Review What To Do if a Problem Arises

In the RED studies, we heard over and over from patients that what worried them most about leaving the hospital is that they would not be able to reach their doctor (or any other responsible clinician) if they had a problem. Therefore, an important component of the RED system is that each patient be told before discharge how to 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 [he or she] 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 certainly hope that you will do well at 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. Also point out that the patient can call the DE with questions.

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

New medicine side effects.

Difficulty getting medicines.

Worsening symptoms or loss of function.

Also make sure your patient knows what constitutes an emergency (e.g., sudden and severe pain, uncontrolled bleeding) and what should be done in case of an emergency (i.e., call 911; return to the hospital). Coach your patient on what might be normal difficulties associated with his or her condition (e.g., with congestive heart failure, shortness of breath when you exert yourself) versus a more acute situation (e.g., sudden, severe shortness of breath).

50. 7. Postdischarge Components of the RED

51.7.1. Transmit the Discharge Summary to the Postdischarge Clinician

Another important component of the RED is to ensure that the clinical information from the hospitalization is transmitted to the clinician responsible for the patient's care 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 is to transmit the patient's hospital discharge summary and the AHCP to the PCP or the first clinician the patient will see, within 24 hours after discharge. This allows ample time for the clinician to review this information before the patient's followup appointment. Furthermore, if a patient has a problem or question between the time he or she leaves the hospital and the day of the followup appointment, then the PCP will have the information about the hospitalization and can respond to questions or concerns.

This information is typically transmitted by fax or email, but any manner that is rapid and secure is acceptable. It is important to find out the preferences of the outpatient providers to determine the best mode of transmission.

One barrier to timely transmission of the discharge summary is that the discharge summary at many hospitals is not prepared until much later—in many cases, not until 30 days after discharge. If this is the case at your hospital, then it is very important to work with your hospital administration, nursing and medical leadership, and patient safety officer to implement policies 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.

52.7.2. Provide Telephone Reinforcement of the Discharge Plan

The final component of the RED is to reinforce the AHCP by calling the patient at home in the 2 or 3 days after discharge. It is important to note that this call is not a "social call" but an action-oriented call 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 Tool 2, "How To Begin the Re-Engineered Discharge Implementation at Your Hospital." The content and procedures of the postdischarge telephone call are described in Tool 5, How To Conduct a Postdischarge Followup Phone Call.

53.7.3. Staff a Discharge Educator Help Line

If several staff members fulfill the DE role, one central phone number should be given to patients to contact a DE. The DE can serve as a point of contact for the time between hospital discharge and the patient's first ambulatory care appointment. Your hospital will decide if this line should be covered 5 or 7 days a week. When possible, calls should be returned within 24 hours. Keep a log of when calls were received and when they were returned, as well as the nature of the call and its resolution.

54. 8. Other Teaching Opportunities Included in the AHCP

The AHCP provides other opportunities to assist the patient before discharge. These are contained in the Workbook and are printed as part of the AHCP. In addition, frequently educational material is presented by other providers in the hospital that can be reinforced as part of the care transition process. The AHCP is printed with a pocket folder to include other educational materials or documents as needed. These items include:

Dietary advice: Dietary advice can play an important role in preventing readmission. For example, diet can affect anticoagulation therapy, glucose control, and response to congestive heart failure treatment. Review the patient's chart to determine if the patient has been placed on a special diet. Modified diets are frequently misunderstood by patients and their families. Review materials with patients and families and reinforce instructions using the teach-back method.

Activity level: Is it important for the patient to start walking everyday? Is there a weight limit for carrying? Is there a driving restriction? Depending on the patient's circumstances, it may be very important to reinforce the importance of activity instructions and limitations and to include reminders about this in the AHCP.

Self-care: Patients frequently have questions about self-care activities (e.g., wound care) that will be needed. Simple illustrations may be particularly useful.

Substance abuse and smoking cessation: When addictions are identified, you can address whether the patient is interested in intervention or referral for treatment. These details may be added to the AHCP.

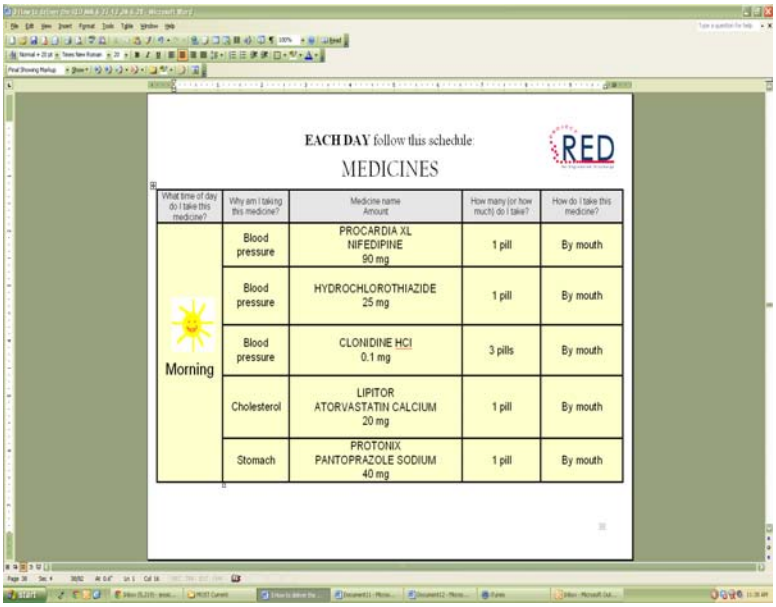
Advanced care planning: Patients who have not assigned a health care proxy or established advanced directives may need additional support to understand why this is useful and how to do this.

Document these additional teaching opportunities in the Workbook, and note the date when you complete teaching about them.

55. Appendix A. Components of After Hospital Care Plan (AHCP)

AHCP Example: Cover Page

AHCP Example: Medicine Schedule

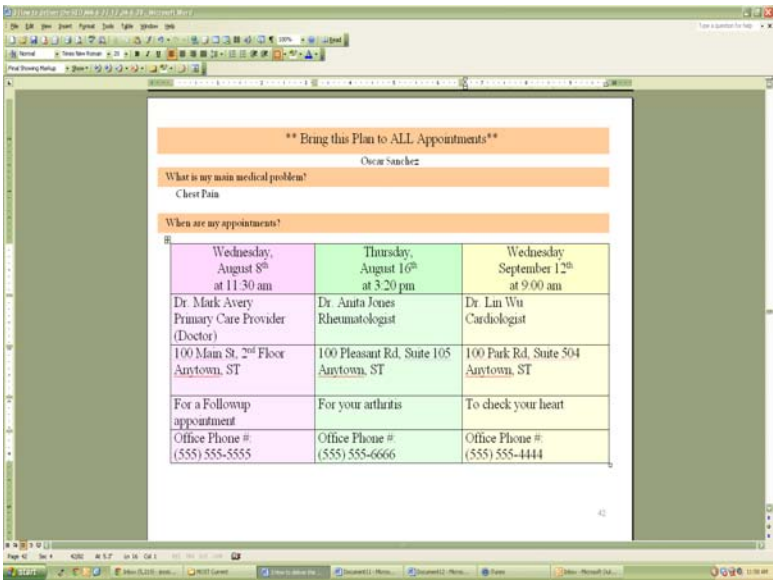


EACH DAY follow this schedule:

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

AHCP Example: Appointment Page



** Bring this Plan to ALL Appointments**

Oscar Sanchez

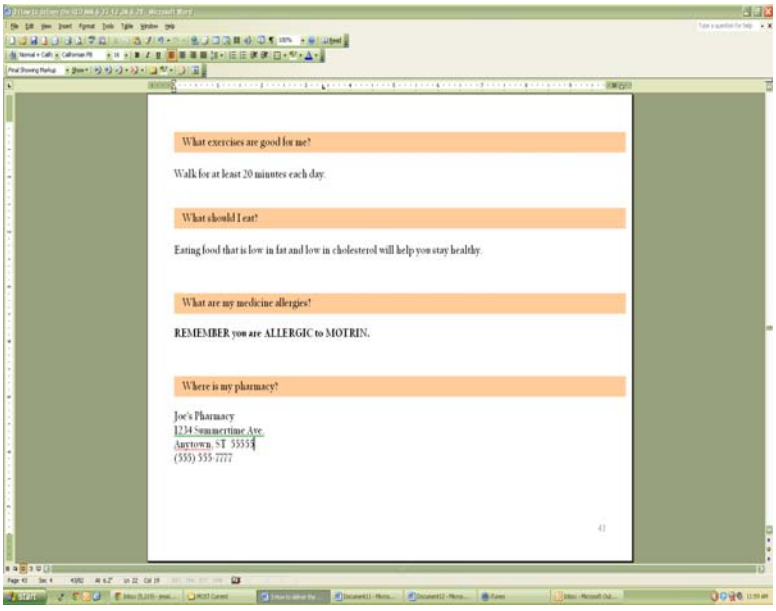
What is my main medical problem?

Chest Pain

When are my appointments?

Wednesday, August 8th at 11:30 am	Thursday, August 16th at 3:20 pm	Wednesday September 12th at 9:00 am
Dr. Mark Avery Primary Care Provider (Doctor)	Dr. Anita Jones Rheumatologist	Dr. Lin Wu Cardiologist
100 Main St, 2nd Floor Anytown, ST	100 Pleasant Rd, Suite 105 Anytown, ST	100 Park Rd, Suite 504 Anytown, ST
For a Followup appointment	For your arthritis	To check your heart
Office Phone #: (555) 555-5555	Office Phone #: (555) 555-6666	Office Phone #: (555) 555-4444

AHCP Example: Additional Information



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.

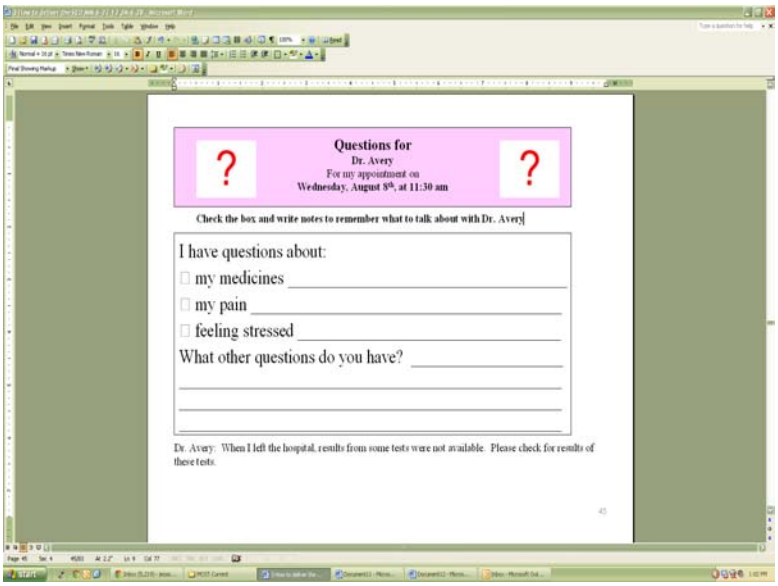
What are my medicine allergies?

REMEMBER you are ALLERGIC to MOTRIN.

Where is my pharmacy?

Joe's Pharmacy
1234 Summertime Ave.
Anytown, ST 55555
(555) 555-7777

AHCP Example: Patient Activation Page



Questions for
Dr. Avery
For my appointment on
Wednesday, August 8th, at 11:30 am

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

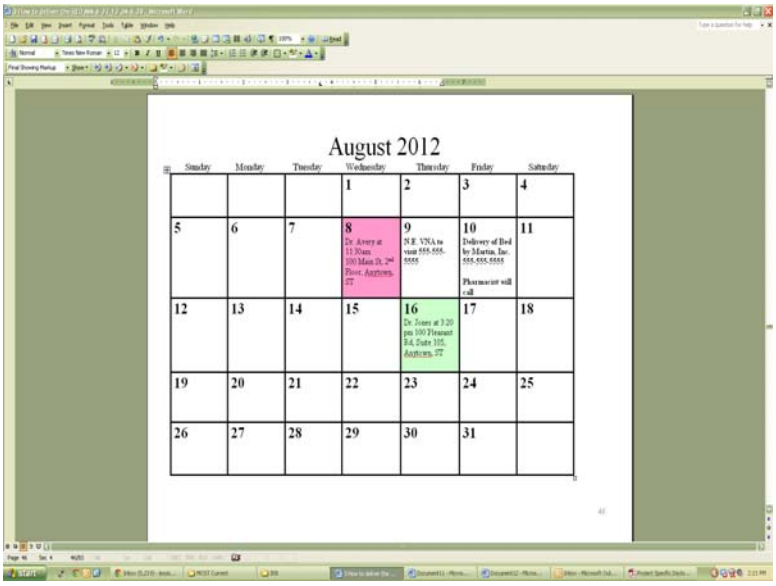
I have questions about:

- ☐ my medicines _____
- ☐ my pain _____
- ☐ feeling stressed _____

What other questions do you have? _____

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

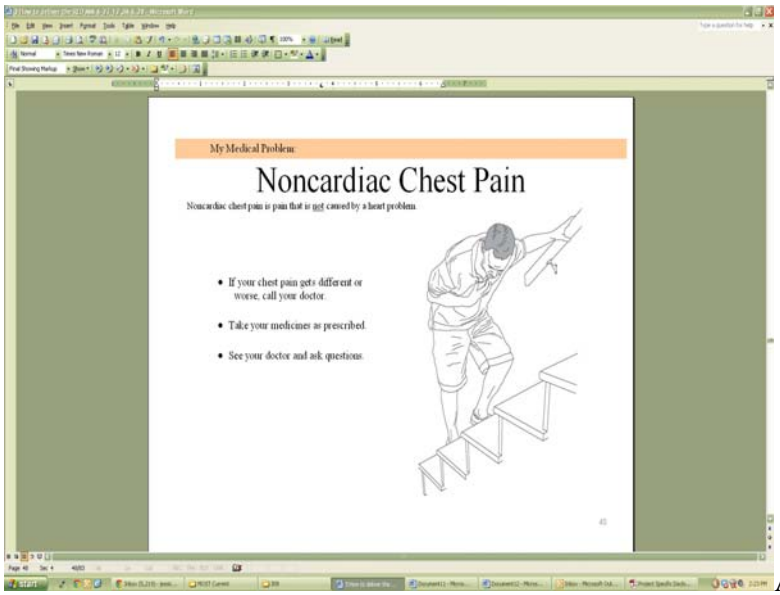
AHCP Example: Appointment Calendar



August 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8 Dr. Avery at 11:30am, 100 Main St. 2nd Floor, Anytown, ST	9 S.E. VNA to visit 555-555-5555	10 Delivery of Bed by Martin, Inc. 555-555-5555 Pharmacist will call	11
12	13	14	15	16 Dr. Jones at 3:20 pm 100 Pleasant Rd, Suite 105, Anytown, ST	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

AHCP Example: Diagnosis Information



Appendix B. Example After Hospital Care Plan (AHCP)

Bring This Plan to ALL Appointments

After Hospital Care Plan for:

Oscar Sanchez

Discharge Date: August 1, 2012

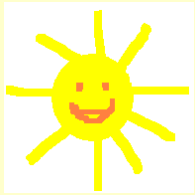
TRY TO QUIT SMOKING: Call Jon Rondovich at (xxx) xxx-xxxx at Boston Medical Center.

Question or Problem about this Packet? Call your Discharge Educator: (xxx) xxx-xxxx

Serious health problem? Call Dr. Mark Avery: (xxx) xxx-xxxx

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
	Heart	ASPIRIN EC 325 mg	1 pill	By mouth
	To stop smoking	NICOTINE 14 mg/24 hour	1 patch	On skin

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?
	Then, after 4 weeks use → Blood pressure	NICOTINE 7 mg/24 hour	1 patch	On skin
	Blood pressure	COZAAR LOSARTAN POTASSIUM 50 mg	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5% solution	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% solution	1 drop	In your left eye

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?
 Evening	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5 % solution	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

** Bring this Plan to ALL Appointments**

Oscar Sanchez

What is my main medical problem?

Chest Pain

When are my appointments?

Wednesday, August 8 at 11:30 a.m.	Thursday, August 16 at 3:20 p.m.	Wednesday September 12 at 9:00 a.m.
Dr. Mark Avery Primary Care Provider (Doctor)	Dr. Anita Jones Rheumatologist	Dr. Lin Wu Cardiologist
100 Main St, 2nd Floor Anytown, ST	100 Pleasant Rd, Suite 105 Anytown, ST	100 Park Rd, Suite 504 Anytown, ST
For a Followup appointment	For your arthritis	To check your heart
Office Phone #: (555) 555-5555	Office Phone #: (555) 555-6666	Office Phone #: (555) 555-4444

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 medicine allergies?

REMEMBER you are ALLERGIC to MOTRIN.

Where is my pharmacy?

Joe's Pharmacy
1234 Summertime Ave.
Anytown, ST 55555
(555) 555-7777

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

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

August 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 **Delivery of Bed by Martin, Inc. 555-555-5555**	**2** **N.E. VNA to visit 555-555-5555**	**3** **Pharmacist will call**	**4**
5	**6**	**7**	**8** Dr. Avery at 11:30am 100 Main St, 2nd Floor, Anytown, ST	**9**	**10**	**11**
12	**13**	**14**	**15**	**16** Dr. Jones at 3:20 pm 100 Pleasant Rd, Suite 105, Anytown, ST	**17**	**18**
19	**20**	**21**	**22**	**23**	**24**	**25**
26	**27**	**28**	**29**	**30**	**31**	

September 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 Labor Day	4	5	6	7	8
9	10	11	12 Dr. Wu at 9:00 am at 100 Park Rd, Suite 504, Anytown, ST	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

My Medical Problem:

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 medicines as prescribed.

See your doctor and ask questions.

My Medical Problem:

Hypertension

Hypertension means high blood pressure.

Avoid salty foods.

Take your medicines as prescribed.

See your doctor and ask questions.

Appendix C. AHCP Template for Manual Creation: English-Speaking Patients

** Bring this Plan to ALL Appointments**

After Hospital Care Plan for: [patient name]

Discharge Date: [discharge date]

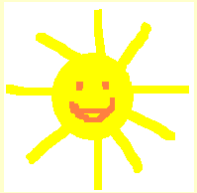
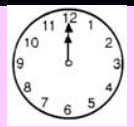
Question or Problem about this Packet? Call your Discharge Educator: (xxx) xxx-xxxx **DE PHOTO HERE**

Serious health problem? Call Dr. _____: (xxx) xxx-xxxx **PCP PHOTO 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				

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				
				

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?
Noon				
 Evening				

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?
 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 everyday.]

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 medicine 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]**

I am having trouble with the stairs in my house.

Someone I live with smokes.

I feel stressed or overwhelmed.

I am having trouble getting food.

There are other things going on in my life that are affecting my health.

Appendix D. Template for Manual Creation of the AHCP: Spanish-Speaking Patients

** Triaga este plan a TODAS sus citas **

Plan de Cuidado Para:

[Patient name]

Dia de Alta: [discharge date]

¿Preguntas o problemas sobre este paquete?
Llame a su transición a la portada enfermera: (xxx) xxx-xxxx **DE PHOTO HERE**

¿Problemas serios de su salud?
Llame a su doctor de cabazera, Dr. [Name]: (xxx) xxx-xxxx **PCP PHOTO HERE**

Cada día sigue este horario:

Medicinas

¿A qué hora del día debo tomar este?	¿Por qué estoy tomando este medicina?	Nombre de la medicina y cantidad	¿Cuántas debo tomar?	¿Cómo debo tomar este medicina?
				

¿A qué hora del día debo tomar este?	¿Por qué estoy tomando este medicina?	Nombre de la medicina y cantidad	¿Cuántas debo tomar?	¿Cómo debo tomar este medicina?
Mañana				

¿A qué hora del día debo tomar este?	¿Por qué estoy tomando este medicina?	Nombre de la medicina y cantidad	¿Cuántas debo tomar?	¿Cómo debo tomar este medicina?
				
Mediodí				
 Tarde				
 Hora de acostarse				

¿A qué hora del día debo tomar este?	¿Por qué estoy tomando este medicina?	Nombre de la medicina y cantidad	¿Cuántas debo tomar?	¿Cómo debo tomar este medicina?
Sólo si usted lo necesita para				
Sólo si usted lo necesita para				

** Triaga este plan a todas sus citas**

[Insert Patient Name]

¿Cuál es mi problema principal médico?

[Insert Primary diagnosis]

¿Cuando son mis citas?

Day, date, and time of appt. (in Spanish)		
Provider name		
Provider site information		
Reason for appt		
Provider phone number		

Agosto 2012

Domingo	Lunes	Martes	Míercoles	Jueves	Vierno	Sabado
			1	**2**	**3**	**4**

5	**6**	**7**	**8**	**9**	**10**	**11**
12	**13**	**14**	**15**	**16** Information of the appointment	**17**	**18**
19	**20**	**21**	**22**	**23**	**24**	**25**
26	**27**	**28**	**29**	**30**	**31**	

¿Cuales ejercios son mejores para mi?

¿Que debo comer?

¿Cuáles son mis alergias a las medicinas?
[list medicine allergies].

¿Donde esta mi farmacia?
[Insert pharmacy name, location, contact information]

{If applicable, include:}

Trate de dejar de fumar: Llame [contact information]

Preguntas para [provider name]

Para mi cita en
Day, date, and time of appointment (in Spanish)

Marque esta caja y escriba notas para recordarse cuando hable con [provider name]

Tengo preguntas acerca de:

Mis medicinas _____

Mi dolor _____

Se siente estresado _____

¿Qué otras preguntas tienes? _____

_____

_____

_____

56. Appendix E. RED Discharge Preparation Workbook

Patient Name _____ MRN _____ DOB _____

Room # _____

Date of admission _____

	Language preference	**Interpreter/Translation Needed (Y/N)**

Spoken communication		
Written materials		
Phone communication		

Fill out Contact Sheet for patient, proxy, and caregiver contact information.

MEDICAL TEAM _____

Attending: _____
Pager # _____

_____
Pager # _____

_____
Pager # _____

Case Manager: _____
Pager # _____

Language Services: _____
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 on patient's case)

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 patient's nurse)

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

Contacts with family/caregiver

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

Date	Outstanding Patient Teaching/Information	Date Addressed

1. <u>Diagnoses</u>

Admitting Dx: _____

Comorbidities: _____

Discharge Dxs _____

2. <u>Followup Appointments</u>

PCP Appointment

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

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

PCP Name	**Day / Date / Time**
Clinician to see at appt (if not PCP)	**Location**
	Address/Floor: **Phone #:** **Fax #:**

Does patient have transportation to PCP appt?

____ Yes ___ No ____ Transportation options discussed:

Team appt. requests: _____

Additional Appointments, Tests, or Lab Work to be done POSTDISCHARGE

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

Day / Date / Time	**Phone and Fax #**	**Reason / Test / Lab**
	Ph: **Fax**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
	Ph: **Fax**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Phone and Fax #	Reason / Test / Lab
	Ph: **Fax**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Phone and Fax #	Reason / Test / Lab

	Ph: **Fax**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	**Phone and Fax #**	**Reason / Test / Lab**
	Ph: **Fax**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

3. <u>Medicine</u>

Allergies ____ No known allergies ____

Allergy	**Patient Confirm (Y/N)**	**If No, Explain**	**Allergy**	**Patient Confirm (Y/N)**	**If No, Explain**

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	Patient 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: Yes ____ No ____

Type _____

Company name: _____ Contact: _____

Address: _____Phone: _____

Delivery date: _____

Type _____

Company name: _____ Contact: _____

Address: _____Phone: _____

Delivery date: _____

8. <u>Current or New Outpatient Services</u> (ex. VNA, PT)? _____

Service _____

Company name: _____ Contact: _____

Address: _____Phone: _____

Date scheduled: _____

Service _____

Company name: _____ Contact: _____

Address: _____Phone: _____

Date scheduled: _____

Service _____

Company name: _____ Contact: _____

Address: _____Phone: _____

Date scheduled: _____

9. Outstanding Tests/Labs

Tests /Labs Pending	Date Conducted	Results Expected	Who Will Follow Up on the Result

Final teaching completed? Yes ____ Done by: DE ____ Other _____ No ____

Reviewed what to do about problems? Yes ____ No ____

Patient understanding confirmed? Yes ____ No ____

Medicines reconciled with patient and medical team prior to final teaching? Yes ____ No ____

National guidelines checked prior to final teaching? Yes ____ Date: _____ No ____

AHCP given and reviewed by DE with patient? Yes ____ Time spent: ____minutes DE____

No ____ Date mailed: _____

If mailed, was patient called by DE to review AHCP? Yes ____ Date: _____ DE ____ No ____

Communication/Notes

57. Appendix F. Contact Sheet

If possible, pull information from patient's medical record. Confirm correct information with patient. Identify the best time of day or days to reach the patient and other contacts.

Patient Name: _____

OK to send letter (Y / N)

Address
Street _____Apt #_____

City, State _____ ZIP Code _____

Email address _____

Preferred spoken language: _____

Interpreter needed? (Y/N) _____

Preferred phone number: __ home __ cell phone __ work

Home Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Cell Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Work Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Contacts

Name of Contact 1: _____

Relationship: _____
Caregiver? (Y/N) __
Proxy? (Y/N) __
Designated to receive followup phone call? (Y/N) __
Notes: _____

_____

Preferred spoken language: _____

Interpreter needed? (Y/N) _____

Preferred phone number: __ home __ cell phone __ work

Home Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Cell Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Work Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Contacts

Name of Contact 2: _____

Relationship: _____
Caregiver? (Y/N) __
Proxy? (Y/N) __
Designated to receive followup phone call? (Y/N) __
Notes: _____

_____

Preferred spoken language: _____

Interpreter needed? (Y/N) _____

Preferred phone number: __ home __ cell phone __ work

Home Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Cell Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

Work Phone: ( )_____ OK to leave message? (Y/N)____

Best time to call: _____

58. Appendix G. Examples of Diagnosis Pages

Congestive Heart Failure.

Heart failure, also called Congestive Heart Failure is a serious condition in which the heart can no longer pump enough blood to the rest of the body.

<u>Things you need to do:</u>

Fill all of your medicine prescriptions,
finish your medicine and take as directed.

Rest as needed.

Weigh yourself daily and write it down.

Call your doctor right away if you have:
-Weight change by ___ pounds for ___ days
-Sudden weakness
-Trouble breathing
-Serious cough

Do not smoke. Avoid other's smoke.

Keep all of your follow-up appointments.

Pneumonia.

Pneumonia is an infection of the lungs.

Things you need to do:

Drink plenty of fluid, such as water, each day.

Get plenty of rest. When you no longer have a fever or trouble breathing, you can go back to your regular activity.

Fill all of your medicine prescriptions, finish your medicine and take as directed.

Don't smoke. Avoid other's smoke.

Call your doctor if your breathing worsens or you develop frequent or loose stool that lasts more than a few days.

Chronic Obstructive Pulmonary Disease.

Chronic Obstructive Pulmonary Disease (also called COPD) is a condition in which some of your airways are blocked, making it hard for you to breathe.

<u>Things you need to do:</u>

Fill all of your medicine prescriptions, finish your medicine and take as directed.

Do not smoke. Avoid smoke, pollution, and extreme changes in temperature and humidity.

Rest as needed.

Fill all of your medicine prescriptions, finish your medicine and take as directed.

Keep all of your follow-up appointments.

Acute Myocardial Infarction.

Acute myocardial infarction (also called heart attack or AMI) occurs when blood cannot reach a part of your heart. This causes heart damage.

<u>Things you need to do:</u>

Fill all of your medicine prescriptions, finish your medicine and take as directed.

Call your doctor if:
-You have unexplained and lasting trouble breathing.
-Your heart symptoms change or get worse.

Ask your doctor what other symptoms to watch out for.

Do not smoke. Avoid other's smoke.

Limit the amount of alcohol you drink.

Diarrhea.

Diarrhea is loose, watery, and frequent stool.

<u>Things you need to do:</u>

Drink plenty of fluids, such as water.

Fill all of your medicine prescriptions, finish your medicine and take as directed.

Wash your hands before eating, preparing food, touching others, and after you visit the bathroom.

Weigh yourself each day and write down the results. Call your doctor if you lose more than 3 pounds over several days.

Call your doctor if you are still having frequent diarrhea after 5 to 7 days.