# Overview Process / Roles Re-Engineered Discharge for Skilled Nursing Facilities[1]

Please use this as a reference to identify who in your organization will be responsible for each task.

| | Admission Assessment | Role |
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| **Assess Needs: Ascertain need for and obtain language assistance** | ❑ Determine patient and caregivers' language proficiencies.<br>❑ Find out about preferred languages for oral communication, phone calls, and written materials.<br>❑ 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.<br>❑ Contact VNA to establish any necessary short term home care services.<br>❑ Find out if patient already has any durable medical equipment (DME) at home.<br>❑ Use ASAP and VNA Referral Workflow to establish services. | |
| **Identify primary caregiver(s)** | ❑ Identify the primary caregiver(s).<br>❑ Assess the primary caregiver(s) needs in order to develop a realistic plan for the next stage of care for the patient.<br>❑ Integrate the primary caregiver(s) needs into the After Nursing Home Care Plan (ACP).<br>❑ Share primary caregiver(s) information with the next setting of care.<br>❑ Provide telephone reinforcement of the ACP.<br>❑ Prior to patient's discharge, determine if patient or caregiver(s) will be point of contact for follow-up calls. | |

| | Prepare for Discharge | Role |
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| **Make appointments for follow-up care** (e.g., medical appointments and post discharge tests/labs). | ❑ Determine primary care and specialty follow-up needs.<br>❑ Identify providers (if patient does not have) based on patient preferences: gender, location, specialty, health plan, etc.<br>❑ Determine need for scheduling future tests.<br>❑ Make appointments with input from the patient and/or caregiver regarding the best time and date for the appointments.<br>❑ Instruct patient and/or caregiver in any preparation required for future tests and confirm understanding.<br>❑ Discuss importance of clinician appointments and tests/labs.<br>❑ Inquire about traditional healers and ensure that traditional healing and conventional medicine are complementary.<br>❑ 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.<br>❑ 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.<br>❑ 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.<br>❑ Discuss who will review the results and when and how the patient and/or caregiver will receive this information. | |
| **Organize post discharge outpatient services and durable medical equipment (DME).** | ❑ Collaborate with the care team to ensure that DME is obtained.<br>❑ Document all contact information for medical equipment companies, home health services, and ASAPs on the ACP 7-10 days prior to discharge.<br>❑ 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 | Role |
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| **Educate the patient about his or her diagnosis and medicines during the patient's stay.** | ❑ Provide education on primary diagnosis and comorbidities.<br>❑ Explain what medicines to take, emphasizing any changes in the regimen.<br>❑ Review each medicine's purpose, how to take each medicine correctly, and note important side effects.<br>❑ Confirm that patient has enough medicines to get to next appointment and/or the ability to obtain them (transport, assistance).<br>❑ 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.<br>❑ Communicate with the inpatient team regarding ongoing plans for discharge.<br>❑ Create an ACP, the easy-to-understand discharge care plan.<br>❑ Review and orient the patient and caregiver to all aspects of the ACP.<br>❑ 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.<br>❑ Show when & how to contact providers following discharge – provide numbers and plan for regular and off-hours (e.g., evenings/ weekends).<br>❑ Instruct on what constitutes an emergency and what to do in cases of emergency and nonemergency situations. | |

| | Discharge Plan Review | Role |
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| **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.<br>❑ Have them review plan for:<br>❑ Medication<br>❑ Appointments<br>❑ Labs<br>❑ Home services<br>❑ Equipment<br>❑ 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.<br>❑ Provide ACP to patient and/or caregiver at discharge. | |

| | Post Discharge Follow-Up | Role |
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| **Provide telephone reinforcement of the discharge plan within 2 business days after discharge from the SNF.** | ❑ Reinforce the ACP.<br>❑ Use provided check-list to verify that all services are in place, according to the plan.<br>❑ 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.<br>❑ 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<br>❑ 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