PREVENTING AVOIDABLE EPISODES

PAVE

Smoothing the Path for Better Transitions

Hospital Discharge Passport

The list of Hospital Discharge Passport standards has been developed through the collaborative effort of Care Transitions Workgroup of the Health Care Improvement Foundation's PAVE Project. It has been designed incorporating all of the critical components of an effective care transition at hospital discharge.

Services to Provide

- ☐ Follow-up appointment within seven (7) days of discharge made with Primary Care Provider
- ☐ Follow-up appointments made with specialists, others
- ☐ Follow-up tests and procedures scheduled; patient/caregiver, providers notified
- ☐ Dates of appointments/procedures/labs/tests, names of providers and phone numbers provided to patient/family
- ☐ Home Health Services referral, if required; Agency name and phone number provided to patient/family
- ☐ DME/Supplies/ Other referrals, if required; Agency name and phone number provided to patient/family

Notification

- ☐ Discharge care plan sent to Primary Care Provider and specialists at discharge
- ☐ Payor/Insurer notified of patient's discharge

Patient Education

- ☐ Patient activation/self-management survey conducted to determine patient's level of understanding of his/her medical condition and care plan
- ☐ Discharge teaching provided using Teach Back; patient/family asked to repeat discharge instructions
- ☐ Copy of discharge care plan provided to patient/family
- ☐ Relevant educational materials provided to patient/family
- ☐ Patient educated on "red flags" and who to contact if they occur
- ☐ Patient provided with the name and number of person to contact regarding pending results of tests/labs, etc.

Medication Reconciliation

- ☐ Medication Reconciliation completed (including assessment of financial and logistical means to fill prescriptions)
- ☐ Discharge prescriptions/medications provided to patient

For High Risk Patients (per Risk Assessment)

- ☐ Follow-up phone call at home within 48 hours of discharge scheduled/conducted
- ☐ Patient referred to Health Coach for evaluation and home visits
- ☐ Pharmacy consultation considered/completed
- ☐ Depression screen completed

For Transfers: Documents/information to provide to the receiving facility to ensure an adequate "handover" include:

- ☐ Transfer forms
- ☐ Medication reconciliation forms
- ☐ Red flags
- ☐ Plan of care
- ☐ Isolation issues
- ☐ DNI-DNR status
- ☐ Last flu and pneumonia immunizations
- ☐ Infections, including those that may be pending
- ☐ Behaviors to be noted

Health Care Improvement Foundation, August 2011