The Ideal Hospital Discharge
CHAMP, University of Chicago

Components
1. Active advanced planning
   – Anticipation from admission
   – SHx: lives whom? ADLs & IADLs?
   – Hosp course: delirium, deconditioning, medical Rx
2. Communication
   – In hospital and at D/C: case managers, family, PCP
   – Inter-facility: paperwork; direct phone call
3. Core information elements:
   • Medical needs
     – Summary of admitting problems and course
     – Active Problem list and allergies
     – Recent important and pending labs
     – Reconciled Med List (admit meds and all changes)
     – Advance directives: DPOA-HC, preferences, goals
   • Functional support (ADL, IADL)
     – Disposition: where from and where next
     – Functional status: baseline and present
     – Social support and contact info
   • Nursing needs: monitoring (BP, DM, CHF), wounds, IVs
   • Rehabilitative needs: PT, OT, speech

Possible D/C Sites

Home    Home w/ Services
Acute Rehab    SNF Rehab

(over)
DETERMINING DISCHARGE DESTINATION

From Home  ➔  To Home
- Recovering ADL independence or stable baseline
- Sufficient and willing caregiver(s) to provide:
  - Safety/supervision
  - Meals
  - Medication supervision
  - ADLs and IADLs support
- No skilled nursing or PT/OT needs

Same as Home to Home except:
- Has Skilled nursing or PT/OT needs
- Skilled nursing care and PT covered by Medicare or insurance

From Home  ➔  To Home + Services

From Home  ➔  To Acute Rehab
- Needs and can tolerate intensive PT/OT (>1 hr/day)
- Medically unstable for SNF
- Needs frequent MD evaluation (> q2-4 wk)
- Rising Cr, dropping Hgb
- Meds need frequent adjustment (in < 24-48 hr)
- Needs telemetry, daily/STAT labs
- No need or unable to tolerate acute rehab
- Lack of sufficient and willing caregiver(s)
- Skilled nursing needs (eg, wounds, IVs)
- 3-night stay for Medicare SNF coverage

From Nsg Home  ➔  To SNF Rehab

Unless new Rx NH can’t support (eg, NGTube)

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