

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, lvs

• Rehabilitative needs: PT, OT, speech

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

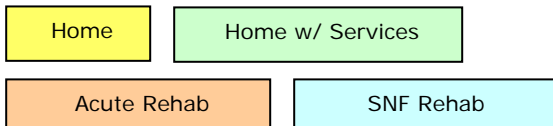
• Functional support (ADL, IADL)

- Disposition: where from and where next
- Functional status: baseline and present
- Social support and contact info

• Nursing needs: monitoring (BP, DM, CHF), wounds, lvs

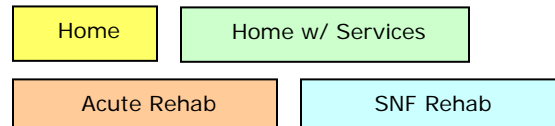
• Rehabilitative needs: PT, OT, speech

Possible D/C Sites



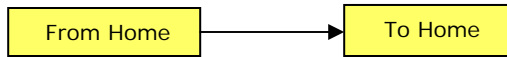
(over)

Possible D/C Sites

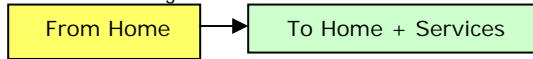


(over)

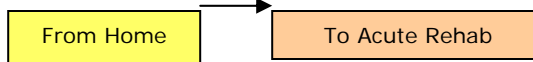
DETERMINING DISCHARGE DESTINATION



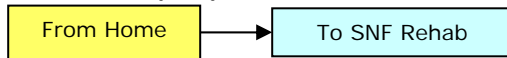
- Recovering ADL independence or stable baseline
- Sufficient and willing caregiver(s) to provide:
 - Safety/supervision
 - Meals
 - Medication supervision
 - ADLs and IADLs support
- No skilled nursing or PT/OT needs



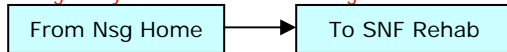
- Same as Home to Home except:
- Has Skilled nursing or PT/OT needs
 - Skilled nursing care and PT covered by Medicare or insurance



- 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

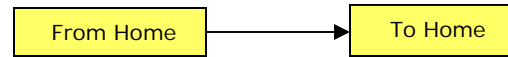


- No need or unable to tolerate acute rehab
- Lack of sufficient and willing caregiver(s)
- Skilled nursing needs (eg, wounds, IVs)
- 3-night stay for Medicare SNF coverage

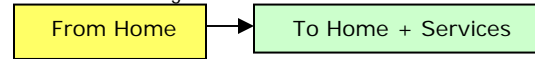


Unless new Rx NH can't support (eg, NGTube)

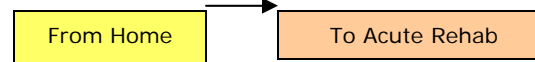
DETERMINING DISCHARGE DESTINATION



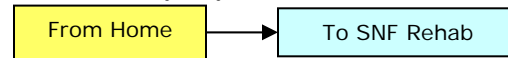
- Recovering ADL independence or stable baseline
- Sufficient and willing caregiver(s) to provide:
 - Safety/supervision
 - Meals
 - Medication supervision
 - ADLs and IADLs support
- No skilled nursing or PT/OT needs



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



- 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



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