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Transitions of Care Practitioner Checklist

Proper transitions of care for patients experiencing venous thromboembolism (VTE) are an increasingly critical component for improving outcomes. As part of the *Improving DVT/PE Transitions of Care* program, the following checklists are provided to help healthcare providers with proper care coordination for their patients discharged after a deep vein thrombosis (DVT) or pulmonary embolism (PE). Hospitals should identify staff responsible for conducting transition of care planning activities.

Instructions: Complete checklist before patient discharge.

1 During Discharge Planning Meeting

Patient Name: _____

- ☐ Educated patient and family about condition[1]
- ☐ Discussed progress toward patient, family, and healthcare provider goals[1]
- ☐ Explained medications to patient and family, including dosing and regimen[1]
  - ◯ Morning ◯ Noon ◯ Evening ◯ Bedtime
  - ◯ Other _____
- ☐ Assessed patient's health insurance status and ability to access postdischarge treatments[2,3]
- ☐ Assessed other barriers that may prevent patient from meeting treatment goals (eg, lack of support at home)[1,2]
- ☐ Involved patient and family in care practices (eg, assisting with rehabilitation)[1]
- ☐ Discussed patient and family questions[1]
- ☐ Reviewed discharge instructions as needed[1]
- ☐ Asked patient and family to restate provided information to ensure understanding (teach-back method)[1]
- ☐ Offered to schedule follow-up appointments with outpatient providers[1]

Healthcare provider and appointment date/time[1]:

Specialist (if applicable): _____

Date: _____ Time: _____

Primary care physician: _____

Date: _____ Time: _____

Other: _____

Date: _____ Time: _____

2 Day of Discharge

Medication

- ☐ Reconciled medication list[1]
- ☐ Reviewed medication list and instructions with patient and family[1]
- ☐ Reviewed reason for taking medication, potential side effects, and storage instructions with patient and family[2]
- ☐ Asked patient and family to restate provided information to ensure understanding (teach-back method)[1]

Care plan

- ☐ Coordinated and documented all transition services and care (eg, medications, home care, rehabilitation, long-term care)[2]
- ☐ Gave patient and family a copy of the care plan[1]

Appointments and contact information[1]

- ☐ Scheduled follow-up appointments:

Physician: _____

Date: _____ Time: _____

Other healthcare provider:

_____

Date: _____ Time: _____

- ☐ Wrote down appointments and contact information for follow-up healthcare providers after discharge
- ☐ Provided patient/caregiver with name and contact information of healthcare provider/ case manager to contact with any questions or concerns post-discharge

Adapted from AHRQ IDEAL Discharge Planning Overview, Process, and Checklist and NTOCC Elements of Excellence in Transitions of Care. For more information, visit www.ahrq.gov and www.ntocc.org.

References: 1. Agency for Healthcare Research and Quality. IDEAL Discharge Planning Overview, Process, and Checklist. Rockville, MD: AHRQ; March 2013. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf. Accessed June 8, 2018. **2.** National Transitions of Care Coalition. Elements of excellence in transitions of care (TOC): TOC checklist. http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf. Accessed June 8, 2018. **3.** Agency for Healthcare Research and Quality. Tool 3: How to deliver the Re-Engineered Discharge at your hospital. Rockville, MD: AHRQ; March 2013. http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool3.html. Accessed June 8, 2018.

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