Appendix B

Care Coordination Recommended "Bundle"

Risk Screens

- Broad screen (Early Screen For Discharge Planning [ESDP]) on all adult patients upon admission
- Functional screen (activity and mobility assessment)
- 8 P's where indicated for decision-support

Interdisciplinary Care Planning

- Mandatory interdisciplinary rounds, with goal of real-time communication and care and transition planning *(every patient, every day)* -- all providers present

Patient/Family Education

- Teachback
- Healthcare literacy
- After Hospital Discharge Plan focused upon "Four Pillars" (self-care management, medication management, disease-specific information, and red flags to report)

Medication Management

- Improved Discharge Medication List
- Identify new (i.e. meds started during hospitalization) "high risk" medications
- Post-discharge phone call for high risk patients
- Patient education by pharmacist
- Medication reconciliation
- "Meds in hand" at discharge

Primary Provider Handoff

- All DC summaries within 5 days of discharge pushed out to PCP, specialists, and follow-up provider
- *Accurate* provider information
- Provider to have DC summary *prior to* follow up appointment
- Appointment in hand for all high risk patients

ED Management

- Risk screening on presentation and before discharge
- Enhanced PCP communication (fax/real-time)
- Disease-specific ED-based interdepartmental algorithms (e.g. ED/Cardiology Collaborative)
- Expansion of Observation services
- Follow-up appointments for PCP or specialty care clinics

Transitions of Care

- Bridge to Home/Health Buddy
- Transition guides (high risk/medical issues)
- Community social work (high risk/social issues)
- PAL Line (follow-up phone calls)
- Follow-up appointments

Appendix B

- Appropriate post-acute referrals (e.g. Skilled Home Care, RPM, Skilled Nursing Facility/Long-Term Care, Rehab [in-home or facility], Palliative Care/Hospice, etc.)