SUCCESSFUL HOSPITAL TO HOME PLANNING

Get Out of the Hospital and **Stay Out** of the Hospital!

MVP® HEALTH CARE

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Take action: Plan a successful hospital discharge!

Work with the hospital discharge team/planner to make a follow-up plan for home:

- Make a complete list of your medications, including dose and frequency.
- Ask for help to schedule a follow-up doctor appointment for seven days after you leave the hospital.
- Include family and friends who can help with your discharge and treatment planning.
- Let the hospital discharge planner know of special needs you have, such as transportation.
- Learn important details about your condition and how to best take care of yourself.

Bring your hospital discharge plan and medications list to your follow-up appointment.

PLAN:

- To ask questions about what you do not understand
- A thorough review of medications when admitted and when discharged
- To see your doctor within seven days of discharge
- To review your follow-up plan for home with family and friends who will be helping you
- To complete the checklist on the next page to help you stay healthy at home and not return to the hospital.

TAKE ACTION!

At all times, carry important information about your condition, medications, doctor and pharmacy contact information.

Lessen your chances of returning to the hospital.

Complete this checklist for successful hospital-to-home planning.

☐ Have a family member or friend help you listen to your discharge instructions.

NAME OF HELPER(S)

☐ Review all medications. Be clear about:

- ✔ Any new medications or medication changes
- ✔ When to take each medication
- ✔ What to do if you miss a dose
- ✔ Any signs or symptoms to watch for and when to contact the doctor
- ✔ If taken with food or not
- ✔ When you are safe to resume driving

☐ Get any new prescriptions filled before you get home

☐ Ask the hospital to give you several copies of your new medication schedule.

- ✔ Post a copy in an easy-to-see place at home
- ✔ Take a copy with you to your follow up doctor appointment

☐ See your doctors within 7 days of discharge.

NAME OF DOCTOR

DATE OF FOLLOW-UP APPOINTMENT

NAME OF DOCTOR

DATE OF FOLLOW-UP APPOINTMENT

☐ Review any special diet instructions.

☐ Ask questions about anything you do not understand and take notes!

☐ Talk about any potential problems you may have following your doctor's instructions.

HAVE A PLAN FOR THE FOLLOWING:

Who will help you when you arrive back home?

HELPER

HELPER

Who will drive you to appointments?

DRIVER

DRIVER

Who will run errands to pick up necessary medical supplies?

HELPER

HELPER

Who will shop for groceries, cook, put out the trash, help with bathing and cleaning and other household needs while you are recovering?

HELPER

HELPER

Who will be there with you when a nurse, aide or therapist comes to your home?

HELPER

HELPER

Who will help you get special equipment you may need, such as grab bars, tub transfer bench, cane, walker or wheelchair?

HELPER

HELPER

GET HOME AND STAY HOME!

About 40%

(nearly 1 million) of hospital readmissions are avoidable

According to Stephen F. Jencks, MD, MPH, author of *New England Journal of Medicine* study.

Take Action!

Make a hospital to home plan that includes a doctor appointment within 7 days of discharge.

About 2/3

of readmissions have something to do with the patients' medications.

According to Matthew J. Schreiber, MD, chief medical officer of Piedmont Hospital. From *Reducing readmissions: How 3 hospitals found success.*

Take Action!

Review all medications. Be clear about any changes.

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