

STEP 1: Identify Patient Needs

If patient has needs in more than one area, default to higher needs level

*Differentiate between Bi-level and Non-Invasive Ventilator (NIV) use

**Barriers to care may include: language, learning disabilities, insufficient support system, financial restrictions, multiple patients with medical needs in home, rural home address

LOW	MEDIUM	HIGH
<ul style="list-style-type: none"> • No home nursing needs • 1-2 pieces of DME • No significant barriers to care** 	<ul style="list-style-type: none"> • < 8 hrs/day home nursing • > 2 pieces of DME • Trach without ventilator support • Bi-level use or < 8 hrs/day NIV* • No significant barriers to care** 	<ul style="list-style-type: none"> • ≥ 8 hrs/day home nursing • Multiple home care providers • Significant trach needs • Invasive ventilator or ≥ 8 hrs/day NIV* • Significant barriers to care**

STEP 2: Plan for Discharge

LOW	MEDIUM	HIGH
<ul style="list-style-type: none"> <input type="checkbox"/> Notify DME: 1-2 days (preferred) <input type="checkbox"/> Communicate needs/changes as soon as they are identified 	<ul style="list-style-type: none"> <input type="checkbox"/> Notify Home Nursing/DME: 1-2 weeks (preferred) <input type="checkbox"/> Establish “touch point” contact(s) in all areas of care (Home nursing/ DME/ Acute care) <input type="checkbox"/> 1-2 “touch point” communications prior to discharge <input type="checkbox"/> Communicate needs/changes as soon as they are identified <input type="checkbox"/> Arrange care conference prior to discharge and invite all areas of care <input type="checkbox"/> Ensure home education is completed with all caregivers prior to discharge <input type="checkbox"/> Ensure DME home assessment is completed prior to discharge 	<ul style="list-style-type: none"> <input type="checkbox"/> Notify Home Nursing/DME: > 3 weeks (preferred) <input type="checkbox"/> Establish “touch point” contact(s) in all area of care (Home nursing/ DME/ Acute care) <input type="checkbox"/> Weekly “touch point” communications prior to discharge <input type="checkbox"/> Communicate needs/changes as soon as they are identified <input type="checkbox"/> Arrange care conference prior to discharge and invite all areas of care <input type="checkbox"/> Ensure home education is completed with all caregivers prior to discharge <input type="checkbox"/> Ensure DME home assessment is completed prior to discharge

MSRC Best Practice: Discharge Planning for Complex Respiratory Patients

Working together we can succeed!

