Discharge Management Program
"Passport"

Goal:
To send Miller's patients home with a discharge plan including knowledge of their conditions, medications, ongoing support options whether or not they receive home care to ultimately reduce re-hospitalizations and provide positive patient outcomes.

Process:

- Patient is provided a "Passport" binder upon admission, which stays with them throughout their rehabilitation stay
- Successful outcomes require a team approach (nursing, dietary, rehabilitation, social services, pharmaceutical, etc.)
- "Passport" binder is referenced and added to during multiple interactions with patient, such as…
    - care plan meetings for discharge planning and educational reference
    - educational training sessions specific to the patients' needs
    - Discharge teaching tools, plans for home setting and needs, community resource list, discharging medication list, education and overview
- "Passport" binder is sent home with patient and encouraged to be taken to all physician appointments

Strategy:

- Evaluate patients living arrangements prior to illness or injury and admission to hospital and/or rehabilitation center
- Medication reconciliation prior to admission
- Determine medications remaining at home to ensure that the patient and family is aware of the danger of taking those medications again without physician's knowledge
- Informing the Primary Care Physician that the patient is in our facility (if they are not caring for them), when that patient will be going home and what medication orders they will be going home with
- Reduce hospitalizations by ensuring that when patients go home they are well prepared and informed to care for themselves
- Enhance nursing opportunities to educate and prepare the patient to return home
- Expand team efforts to ensure that all disciplines do their part
- Expand physician relations and confidence in our nursing and ancillary staff
- Enhance patient and family satisfaction with our nursing and ancillary staff