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## Discharge Planning COVID-19 Screen

Affix patient label

### Criteria for 2019 Novel Coronavirus Discharge Screen

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. The patient is considered a "Person Under Investigation" (PUI) for COVID-19 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. The patient been confirmed as positive for COVID-19                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Patient is being discharged with Home Care Services/Home Hospice            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Did the patient meet criteria for testing?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### Guidance for Discharge to Home/Home with Home Care/Home Hospice Assessment and Patient Education

- |  |  |   |
|--|--|---|
| 1. The patient is stable enough to receive care at home.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 2. Appropriate caregivers are available as needed.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Not Applicable |
| 3. As much as possible, instructions to stay in a specific room and away from other people in the home. Also, instructions to use a separate bathroom, if available.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 4. Resources for access to food and other necessities are available.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 5. If patient is being discharged on anticoagulant, delivery address has been verified and if different than registration, task sent to Pharmacy.  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 6. The patient and other household members have access to appropriate, recommended personal protective equipment (at a minimum gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g. respiratory hygiene and cough etiquette, hand hygiene)? | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 7. There are household members who may be at increased risk of complications from 2019-nCoV infection (e.g. people > 65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions)<br>*see Care Coordination Progress Notes        | <input type="checkbox"/> Yes<br>implement<br>escalation* | <input type="checkbox"/> No             |

### Guidance for Covid-19 Negative Patients Being Discharged Home Who Require Home Care Services

- |   |   |
|---|---|
| 1. Do any household members meet the screening criteria for COVID-19 testing? | <input type="checkbox"/> Yes, contact Home Care/Hospice |
|   | <input type="checkbox"/> No, routine discharge          |

### Screening Criteria for Discharge to Post-acute Facility

- |  |  |   |
|--|--|---|
| 1. The patient is stable enough to receive care at home.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 2. Appropriate caregivers are available as needed.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Not Applicable |
| 3. As much as possible, instructions to stay in a specific room and away from other people in the home. Also, instructions to use a separate bathroom, if available.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 4. Resources for access to food and other necessities are available.   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 5. The patient and other household members have access to appropriate, recommended personal protective equipment (at a minimum gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g. respiratory hygiene and cough etiquette, hand hygiene)? | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 6. There are household members who may be at increased risk of complications from 2019-nCoV infection (e.g. people > 65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions)<br>*see Care Coordination Progress Notes        | <input type="checkbox"/> Yes<br>implement<br>escalation* | <input type="checkbox"/> No             |
| 7. It has been at least seven days since the initial positive test for COVID-19  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 8. Resolution of fever, without use of antipyretic medication  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 9. Improvement in illness signs and symptoms   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |
| 10. Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of nasopharyngeal swabs specimens collected 24 hours apart.  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No             |

### Discharge Disposition Plan/Location

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Home/Home with Homecare/ Home Hospice services positive COVID19 patient<br>COVID-19 Patient education materials provided  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Protective Equipment (PPE) pack provided  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Certified Home Health Agency notified via warm handoff, if applicable  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Post discharge address verified and communicated to Pharmacy (if applicable)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Home/Home with Homecare/ Home Hospice services for COVID19 negative patient with COVID19 positive household member<br>COVID-19 Patient education materials provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Protective Equipment (PPE) pack provided  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Certified Home Health Agency notified via warm handoff, if applicable  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Home with Home Care routine discharge   |                              |                             |
| <input type="checkbox"/> Post-Acute Facility<br>Sent documentation of criteria met with referral   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Post-Acute receiving facility contacted to provide warm handoff  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### Staff Information

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Phone Number: \_\_\_\_\_