Essential Communication Elements Toolkit Resources

ALLIANT HEALTH SOLUTIONS

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Contents

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Overview

High Risk Medication Essential Communication Elements Guide for Transitions of Care

THE PURPOSE OF THIS TOOL

- Improvement of cross-setting management of high risk medications (opioids, anticoagulants, and diabetes medications) during transitions of care to prevent adverse drug events and subsequently reduce emergency department visits, hospitalizations, and readmissions.

An adverse drug event (ADE) is when someone is harmed from a medicine.[1] This can include medication errors, adverse drug reactions, allergic reactions, and overdoses.

About half of ADEs are estimated to be preventable.[2]

Each year, ADEs account for nearly 1.3 million ED visits, of which 350,000 patients are hospitalized for further treatment.[1]

Nearly 5% of hospitalized patients experience an ADE.[2]

Nearly one in five Medicare patients discharged from a hospital are readmitted within 30 days.[4] And one in five patients discharged from hospitals will experience an adverse event within 3 weeks of discharge.[4] More than half of these post discharge adverse events occur due to poor communication among providers, most commonly regarding medication errors.[4]

Improving medication safety and coordination of care → Prevent ADEs → Increase patient engagement → Reduce hospitalizations and harm

The National Action Plan for Adverse Drug Event Prevention identifies common, preventable and measurable ADEs and aligns efforts of Federal health agencies to reduce patient harm.

- The key drug classes identified as high risk for ADEs are anticoagulants, diabetes agents, and opioids.[3]

This toolkit contains documents regarding proper communication between providers during transitions of care in patients taking opioids, anticoagulants, and diabetes medications. Content includes the essential communication elements that should be shared during transitions of care and documented in the chart/electronic medical record.

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Overview

HOW CAN THE ESSENTIAL COMMUNICATION ELEMENTS TOOLS BE UTILIZED?

- Provide the fundamental communication criteria necessary for the proper transition of care related to pain medications, anticoagulants, and diabetes medications.
- Evaluate your facility practices regarding communication of requisite medication-related elements to subsequent providers.
- Identify opportunities for system improvements.

ESSENTIAL COMMUNICATION ELEMENTS GUIDE DOCUMENTS

- Pain Management Essential Communication Elements for Transitions of Care
- Anticoagulation Essential Communication Elements for Transitions of Care
- Diabetes Management Essential Communication Elements for Transitions of Care

1. https://www.cdc.gov/medicationsafety/adult_adversedrugevents.html#:~:text=Adverse%20drug%20events%20cause%20approximately,visits%20for%20adverse%20drug%20events
2. https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events
3. https://health.gov/our-work/health-care-quality/adverse-drug-events/national-ade-action-plan
4. http://www.rimed.org/rimedicaljournal/2015/04/2015-04-15-ltc-vognar.pdf

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Pain Management

PAIN MANAGEMENT ESSENTIAL ELEMENTS FOR TRANSITIONS OF CARE TOOL

Purpose: Adverse drugs events (ADE) have been identified as a major contributor to preventable hospitalizations and emergency department visits. This guide identifies the fundamental provider communication criteria necessary for the safe transition of care for patients receiving pain medication. Additionally, it can be used to evaluate your facility practices regarding communication of requisite pain-related elements to subsequent providers and identify opportunities for system improvements.

Pain Essential Communication Elements	Guidance
Pain diagnosis	Expectation is that pain is clearly indicated as a medical condition, regardless of whether it is a primary purpose for receiving services from the index (i.e., "upstream") provider. Diagnosis NOT to be deduced by evaluation of drug regimen.
Pain category(s) or classification	Pain characterized according to recognized category(s) including but not limited to: acute (e.g., post-operative), subacute, chronic (e.g., cancer and persistent non-cancer), nociceptive, neuropathic, inflammatory, central, or mixed.
Temporal characteristics	Expectation is that duration of pain is communicated to some degree (acute vs. chronic; new diagnosis vs. pre-existing condition [> 30 days])
Pain severity, recent	Subsequent providers are to receive documentation of recent pain symptoms and response to therapy over previous 7 days (longer period preferred, describe full length of stay at index provider if LOS < 7 days). Include overview of severity of pain in recent days as well as frequency and responsiveness to interventions (pharmacological and other).
Pain severity, current	Most recent objective assessment of pain severity is documented and communicated to subsequent providers, including details of date and time of last two assessments and date and time the next assessment is due. Prefer accepted/validated pain scoring method.

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Drug name, dose, strength, formulation, route, and frequency for entire current daily medication regimen	Subsequent providers should receive at the time of transition between care settings, detailed characteristics of all drugs, including opioids prescribed to control pain symptoms, including drug names, dosages, routes, and frequencies. Communication should also include date and time last doses given AND date and times next scheduled doses are due. The location of transdermal patches and the date time of last placement and subsequent removal should be communicated.
Opioid doses administered within the last two 24 hour periods	Subsequent providers should receive a medication administration record of the last two 24-hour periods of opioid dosing including routine around-the-clock and as needed opioids. This can be beneficial in identifying pain management trends. If the drug choice is changed post-transition (e.g., due to availability issues), it is recommended that the receiving provider convert to oral morphine equivalents using a conversion calculator to determine appropriate dosing.
Identification of opioid naïveté in patients starting on an opioid.	Documentation of patient experience with opioid medications through questioning and consultation of the PMP (Prescription Monitoring Program) should be provided to subsequent providers. Long-acting or extended-release opioid formulations should be avoided in opioid naïve patients. Increased education and monitoring should be provided for opioid naïve patients. Standard definitions for opioid tolerance should be used. “Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily, or an equianalgesic dose of another opioid” Source: NIH U.S. National Library of Medicine; DailyMed. Duragesic (Fentanyl Patch) under section ‘Indications and Usage’ Accessible at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d7aade83-9e69-4cd5-8dab-dbf1d7b89bb4

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Presence, frequency, and degree of use of respiratory depressants (benzodiazepines, cough syrup containing alcohol, etc.)	Clinical documentation should clearly characterize presence of medications and/or substances that can cause respiratory depression. A risk vs benefit evaluation should be performed when concomitant use of opioids and respiratory depressants is present.
History of opioid overdose with date(s).	Details of episodes of opioid overdose and whether intentional or unintentional should be communicated to subsequent providers including causative agents if applicable, classification and current stability.
Contact information provided for the subsequent pain management prescriber/ physician.	The name and contact information of the receiving pain management prescriber should be verified and provided to the patient.

Alcohol and/or substance abuse and/or dependence history	Clinical documentation should clearly characterize any current use or history of alcohol and/or substance abuse or dependence, including the frequency and degree of use. If no alcohol and/or substance abuse or dependence exist, clinical documentation should clearly state that the patient has no history.
Behavioral health/mental health history and status	Subsequent providers should receive details of previous and/or ongoing behavioral health concerns/mental health disorders, if known, and their treatment, as well as a detailed characterization of mental status at the time of transition to subsequent providers, if applicable and/or available. Treatment may have implications for pain management or impact patient self-management of pain. If present, all diagnoses, current clinical status, and details of treatment regimens (drug and non-drug) should be described in detail, if possible. If no behavioral health issue or psychiatric illness exists or was previously diagnosed, clinical documentation should clearly state that patient has no known history.

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Respiratory status	Clinical documentation should clearly characterize presence of any acute or chronic respiratory disease and status of treatment regimen, if applicable. If no respiratory disease is present, clinical documentation should clearly state that respiratory status is normal.
Date of last bowel movement	Clinical documentation should indicate when the last bowel movement occurred.
Bowel regimen ordered	Clinical documentation should clearly characterize what medication(s) the patient is on to prevent opioid-induced constipation and the clinical status and current treatment regimens must be described in detail.
Presence of potential barriers to safe medication use (e.g., cognitive impairment, mental health disorders, dementia, visual impairment, etc.)	Clinical documentation should clearly characterize the potential barriers to safe medication use. If present, current clinical status, details of treatment regimens (drug and non-drug), and impact on safe pain self-management or caregiver management should be described in detail.
Fall assessment and history	Frail, elderly patients may experience more catastrophic consequences of falls than younger, healthier patients (e.g., hip fractures). Some objective evaluation of falls risk/frailty may be helpful to subsequent providers, particularly in instances in which they have not yet seen personally (e.g., evening admission to nursing home).
Assessment of patient ability to self-administer current pain regimen	Clinical documentation characterizes in some manner (objectively or in subjective narrative) patient ability to administer and manage all agents prescribed for pain management.
Patient/caregiver/ family member capacity for identifying signs/symptoms of overdose	Clinical documentation characterizes in some manner (objectively or in subjective narrative) patient/caregiver/ family member ability to identify signs/symptoms of an overdose (e.g., respiratory distress, over-sedation, unresponsiveness, pinpoint pupils).

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Caregiver/family member capacity for administering a reversal agent for overdose if reversal agent is available	Clinical documentation characterizes in some manner (objectively or in subjective narrative) caregiver/family member training/ability to administer reversal agent, if available, in the case of opioid overdose.
Instruction to follow safe usage, storage and disposal procedures for the prescribed medication for patients being discharged to home	Patient education is a key component for medication management and safety, especially in regard to controlled substances. Documentation of patient education in regard to medication usage and storage should be shared with providers.
Documentation of provision of educational materials to patient/caregiver	Patient/caregiver education is a key component of quality pain management and an integral part of discharge counseling, particularly as patient's transition between care settings and experience changes in medical status, environment, and medications. Documentation of the provision of educational materials should be shared with subsequent providers. Details of the content of such materials is recommended, but not required.
Assessment of patient/caregiver understanding of the education documented	Clinical documentation should characterize patient comprehension of their pain-related care plan, including monitoring and symptom recognition, medication administration and adherence, and communication with healthcare providers.

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Pain Management

Pain diagnosis	YES ☐ NO ☐
Pain category(s) or classification	YES ☐ NO ☐
Temporal characteristics	YES ☐ NO ☐
Pain severity, recent	YES ☐ NO ☐
Pain severity, current	YES ☐ NO ☐
Drug name, dose, strength, formulation, route, and frequency for entire current daily medication regimen	YES ☐ NO ☐
Opioid doses administered within the last two 24 hour periods	YES ☐ NO ☐
Identification of opioid naïveté in patients starting on an opioid.	YES ☐ NO ☐
Presence, frequency, and degree of use of respiratory depressants (benzodiazepines, cough syrup containing alcohol, etc.)	YES ☐ NO ☐
History of opioid overdose with date(s).	YES ☐ NO ☐
Contact information provided for the subsequent pain management prescriber/ physician.	YES ☐ NO ☐
Alcohol and/or substance abuse and/or dependence history	YES ☐ NO ☐
Behavioral health/mental health history and status	YES ☐ NO ☐
Respiratory status	YES ☐ NO ☐
Date of last bowel movement	YES ☐ NO ☐
Bowel regimen ordered	YES ☐ NO ☐
Presence of potential barriers to safe medication use (e.g., cognitive impairment, mental health disorders, dementia, visual impairment, etc.)	YES ☐ NO ☐
Fall assessment and history	YES ☐ NO ☐
Assessment of patient ability to self-administer current pain regimen	YES ☐ NO ☐
Patient/caregiver/ family member capacity for identifying signs/symptoms of overdose	YES ☐ NO ☐
Caregiver/family member capacity for administering a reversal agent for overdose if reversal agent is available	YES ☐ NO ☐
Instruction to follow safe usage, storage and disposal procedures for the prescribed medication for patients being discharged to home	YES ☐ NO ☐
Documentation of provision of educational materials to patient/caregiver	YES ☐ NO ☐
Assessment of patient/caregiver understanding of the education documented	YES ☐ NO ☐

Anticoagulation

ANTICOAGULATION ESSENTIAL COMMUNICATION ELEMENTS FOR TRANSITIONS OF CARE TOOL

Purpose: Adverse drugs events (ADE) have been identified as a major contributor to preventable hospitalizations and emergency department visits. This guide identifies the fundamental provider communication criteria necessary for the safe transition of care for patients receiving anticoagulants. Additionally, it can be used to evaluate your facility practices regarding communication of requisite anticoagulation-related elements to subsequent providers and identify opportunities for system improvements.

Anticoagulation Essential Communication Elements	Guidance
Anticoagulant(s) currently utilized	Subsequent providers should be informed of all currently prescribed anticoagulants, as well as recently administered agents that are likely still active in the patient's body (e.g. warfarin discontinued a day prior is expected to have continued anticoagulant activity)
Indication(s) for anticoagulation therapy	Documentation provided to downstream providers should include a clear listing of all indications for anticoagulation, acute or chronic
Documentation describing whether the patient is new to anticoagulation therapy or a previous user	Whether a patient is "new to therapy" has implications for thrombotic risk, drug management (e.g. INR stability), and drug duration (e.g. orthopedic prophylaxis). As such, patient initiation of anticoagulation in previous 30 days should be clearly stated for subsequent providers. Patients who have longstanding chronic indication(s) for anticoagulation (e.g. atrial fibrillation) and who then develop a new indication that warrants more intense anticoagulation (e.g. pulmonary embolism) should be considered "new users," in that details of the acute indication and date of therapy modification be communicated.

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If a patient is new to anticoagulation therapy, the start date of anticoagulation is provided	For patients who have initiated anticoagulation within the past 30 days, the explicit date of initiation of anticoagulation must be communicated. For chronic AC users who develop a new indication warranting more intense anticoagulation, the date of AC intensification should be clearly communicated to downstream providers.
Documentation indicating whether treatment for each indication is intended to be acute (short term) or chronic (long term)	Documentation should make it abundantly clear to subsequent providers whether anticoagulation therapy for each listed indication is intended to continue, be reduced in intensity, or discontinued.
If any acute (short term) indications, the intended duration of therapy is communicated	Documentation should include sufficient detail to precisely identify dates of discontinuation or de-escalation, either through provision of explicit stop/change dates (e.g. “stop on Jan 1st, 2015”) OR through calculation (e.g. “treat for 21 days” and actual start date provided).
Date, time, route, dose, and strength of the last 2 doses given	All elements (including strength/product dosage forms as well as the date and time) should be known for doses that have already been administered.
Date, time, and magnitude of next dose due	Although it may be reasonable to forecast when a next dose is due and its magnitude, the product strength and route may not necessarily be known for future administrations (e.g. patient sent to hospital from LTC after receiving stable oral doses and strengths now requires administration via gastric tube).
Most recent assessment of renal function (within past 30 days, with date and results)	Subsequent providers should receive an objective, recent assessment of patient renal function when patients transition from one care setting to another (i.e. most recent assessment performed at the referring care setting). The assessment should explicitly state the method used (e.g. Cockcroft-Gault or MDRD equation), the date, and the numeric result (e.g. creatinine clearance per Cockcroft-Gault of 80 mL/min). In the absence of such an assessment, providers should at a minimum receive sufficient data elements to calculate an estimate of renal function based on a valid formula (e.g. age, gender, weight, and serum creatinine for Cockcroft-Gault) with dates obtained for each. As creatinine clearance (CrCl) is the estimate of renal function most widely utilized for adjusting drug dosages, this estimate of renal function is preferred.

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Documentation of the provision of patient education materials about the anticoagulant	Patient education is a key component of quality anticoagulation management, particularly as patients transition between care settings and experience changes in medical diagnoses and/or acuity. Documentation of the provision of educational materials should be shared with subsequent providers. Details of the content of such materials is recommended, but not required.
Assessment of patient/caregiver understanding of their anticoagulation regimen	Assessment of understanding must include specific mention of patient or caregiver understanding of anticoagulation therapy OR general clinical documentation indicative of patient inability to self-administer and self-monitor medications (e.g. advanced dementia, unconsciousness) OR receiving care setting responsible for all medication administration and monitoring (e.g. acute care admission).
If transitioning to a non-institutionalized setting, expectations for who was responsible for ongoing anticoagulation management	If patient transitioning to non-institutionalized setting (i.e. where responsible medical staff are not implicit) then expectations for who is responsible for ongoing anticoagulation management is clearly stated. Documentation includes contact information for the anticoagulation management provider AND indicates that the third party was aware of that expectation (e.g. was anticoagulation clinic identified and contacted).
If prescribed warfarin, the target INR or INR range is documented	Treatment guidelines and consensus documents recommend specific INR targets and acceptable ranges based on indication for treatment. Prescribers of warfarin should communicate to subsequent providers their target INR and/or acceptable INR range for the specific patient. The intent of this process is to assure that the desired target is communicated, NOT that the target aligns with consensus standards.

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If prescribed warfarin, a minimum of 2–3 consecutive INR lab results are provided (with dates and results)	The trajectory of the INR cannot be ascertained by a single INR value, so subsequent providers must receive 2 or more of the most recent results, regardless of whether the tests were performed by the immediate "upstream" provider or not. For example, a warfarin user residing in the community presents to an emergency department, receives care for 23 hours, and is released to a rehabilitation facility. The expectation would be that ED would share any INR results from tests they performed, as well as additional results from other sources (e.g. obtained from primary care provider).
If prescribed warfarin, the date for when the next INR was due is communicated	Warfarin users presenting to new care settings due to thrombosis or bleeding will likely require immediate evaluation of the INR, regardless of previous monitoring schedules. However, warfarin users may transition across care settings for reasons unrelated to anticoagulation. As such, it cannot be assumed that new INR tests will always be necessary immediately upon arrival to the new setting. To guide therapy, "upstream" providers should communicate when the next scheduled INR test is anticipated as necessary.

Anticoagulants: Coumadin (warfarin), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Savaysa (edoxaban), Lovenox (enoxaparin), Arixtra (fondaparinux), Heparin, Fragmin (dalteparin)

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Anticoagulation

Anticoagulant(s) currently utilized.	YES ☐ NO ☐
Indication(s) for anticoagulation therapy.	YES ☐ NO ☐
Documentation describing whether the patient is new to anticoagulation therapy or a previous user.	YES ☐ NO ☐
If a patient is new to anticoagulation therapy, the start date of anticoagulation is provided.	YES ☐ NO ☐
Documentation indicating whether treatment for each indication is intended to be acute (short term) or chronic (long term).	YES ☐ NO ☐
If any acute (short term) indications, the intended duration of therapy is communicated.	YES ☐ NO ☐
Date, time, route, dose, and strength of the last 2 doses given.	YES ☐ NO ☐
Date, time, and magnitude of next dose due.	YES ☐ NO ☐
Most recent assessment of renal function (within past 30 days, with date and results).	YES ☐ NO ☐
Documentation of the provision of patient education materials about the anticoagulant	YES ☐ NO ☐
Assessment of patient/caregiver understanding of their anticoagulation regimen.	YES ☐ NO ☐
If transitioning to a non-institutionalized setting, expectations for who was responsible for ongoing anticoagulation management.	YES ☐ NO ☐
If prescribed warfarin, the target INR or INR range is documented.	YES ☐ NO ☐
If prescribed warfarin, a minimum of 2–3 consecutive INR lab results are provided (with dates and results).	YES ☐ NO ☐
If prescribed warfarin, the date for when the next INR was due is communicated.	YES ☐ NO ☐

Diabetes Management

DIABETES MANAGEMENT ESSENTIAL COMMUNICATION ELEMENTS FOR TRANSITIONS OF CARE TOOL

Purpose: Adverse drugs events (ADE) have been identified as a major contributor to preventable hospitalizations and emergency department visits. This guide identifies the fundamental provider communication criteria necessary for the safe transition of care for patients receiving diabetes medications. Additionally, it can be used to evaluate your facility practices regarding communication of requisite diabetes-related elements to subsequent providers and identify opportunities for system improvements.

Diabetes Essential Communication Elements	Guidance
Diabetes diagnosis, including subtype classification	The diagnosis of diabetes and the sub-classification (Type 1, Type 2, gestational, iatrogenic, due to pancreatitis or pancreatic obstruction, other) should be clearly indicated as a medical condition for subsequent care providers, regardless of whether it is a primary purpose for receiving services from the index (i.e. “upstream”) provider. The diagnosis is NOT to be deduced by evaluation of drug regimen or prescribed diet.
Duration of diabetes (new diagnosis or chronic)	Subsequent providers should be provided some characterization of the duration of the diabetes diagnosis and/or treatment. Newly diagnosed patients may be more unstable, and hypoglycemia risk has been shown to increase with duration of diabetes. Patients with longstanding diagnosis will likewise be at greater risk of microvascular and macrovascular complications. Such characterizations need not be exact. Terms such as “recently diagnosed” and “diabetic for 5+ years” are acceptable, although more detailed and precise information is preferred such as date of onset (month/year) according to patient medical record.
Recent blood glucose values along with blood glucose monitoring schedule with date and time for when the next blood glucose value is due	Subsequent providers should receive all blood glucose values recorded in the referring health setting in the preceding 7 days, with values over a greater monitoring period preferred. In instances in which the patient duration of stay in the “upstream” setting is less than 7 days, all values recorded in that setting should be provided to subsequent providers.

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Target range for blood glucose	Subsequent providers should receive details (i.e. numeric boundaries) of the blood glucose range targeted for the individual patient while under the care of the referring (i.e. "upstream") provider.
History of hypoglycemic episodes	Subsequent providers should receive a history of hypoglycemia episodes occurring within the last 7 days, including date and time of event, whether loss of consciousness occurred, a list of the current drugs and an explanation for the hypoglycemic event.
Current antihyperglycemic drug regimen	Subsequent providers should receive detailed characterizations of all antihyperglycemic drugs at the time of transition between care settings, including drug names, dosages, routes, and frequencies. The presence of an insulin pump should be communicated with pump settings. Communication should also include date and time of last doses given AND date and times that next scheduled doses are due.
Recent changes in the antihyperglycemic drug regimen	In addition to the current active antihyperglycemic drug regimen, providers should receive details of all recent changes in antihyperglycemia drugs (i.e. at least the past seven days). Documentation should include all newly introduced agents, dose increases, decreases, discontinuations, or "holds", and provide detailed justification for such changes (e.g. hyperglycemic or hypoglycemic events, infection, etc.). If the duration of care in the "upstream" setting was less than seven days, then details of all regimen changes for the full length of care in that setting should be communicated. Rationale for changes between pre-admission medication list and the discharge medication list should be documented.

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Diabetes Management

Identification of and associated rationale for sliding scale insulin order initiated during hospitalization	Long term use of sliding scale orders should be avoided and insulin orders should be standardized post-discharge. In cases where fluctuating needs for insulin are required, sliding scale should be used cautiously and judiciously to avoid hyper or hypoglycemic events and the actual scale being used should be provided. Special attention to patient education on use of sliding scale may be warranted (e.g. differentiate between long acting and rapid acting insulin, patient must know when to self-monitor blood glucose and when to inject the insulin, etc.).
Current diet including whether it is administered via enteral feeding tube and if so, the schedule should be provided	Subsequent providers should be informed of the patient's current recommended diet (e.g. total calories, composition) and, if the patient was in control of food decisions (e.g. outpatient setting), a characterization of patient adherence to the recommended diet should also be communicated. If the diet is administered via enteral feeding tube the documentation should indicate the type of tube (e.g. G-tube, G-J tube, J-tube) and whether nutrition is administered as bolus or continuous feeds.

Age	Patients at the extremes of age may be at greater risk of adverse events, have altered drug clearance (e.g. the very old), or diminished ability to self-manage the disease (e.g. the very young), so patient age should be clearly communicated to all subsequent care providers.
Presence of surgical interventions or trauma/tissue damage	Clinical documentation should clearly characterize any recent instances of tissue damage, regardless of cause.
Presence of dementia	Clinical diagnosis should clearly indicate if there is a pre-admission diagnosis of dementia.
Presence of delirium if known	Clinical documentation should clearly characterize any recent episodes of acute delirium (e.g. past 30 days).

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Diabetes Management

Last value and date of renal assessment	Diabetes is known to advance declines in renal function (i.e. microvascular disease), and renal dysfunction due to any cause may affect drug dosing and contraindications (e.g. metformin). Subsequent providers should receive an objective, recent assessment of patient renal function when patients transition from one care setting to another (i.e. most recent assessment performed at the referring care setting). The assessment should state the method used (e.g. eGFR, Cockroft-Gault or MDRD equation), the date, and the numeric result. Such assessment or values should be dated within the last year.
Current non-antihyperglycemic drug list	Medications unrelated to antihyperglycemic treatment may contribute to hyperglycemia, hypoglycemia, and hypoglycemia unawareness (e.g. beta blockers). Subsequent providers should be provided comprehensive lists of all current medications used so that they can evaluate the possible impact of such medications on the patient's diabetes care plan.
Details of systemic glucocorticoid therapy, if applicable	If currently utilized, clinical documentation should clearly characterize the status of any systemic corticosteroid regimen. Active indications for glucocorticoid therapy must be provided as well as details of the regimen, including temporal factors (acute vs. chronic use, when initiated, etc.), dose trajectory (escalating, deescalating, or stable), and the current drug, dose, route and frequency. Details should include when last dose was given and when next dose is due. Specific dose tapers and/or dose escalation schedule should be provided (e.g. details of the remaining portion of the taper). The absence of corticosteroids from a comprehensive active medication regimen is sufficient to denote absence of systemic corticosteroid use.

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Diabetes Management

Assessment of patient ability to self-administer current diabetes regimen	Clinical documentation characterizes in some manner (objectively or in subjective narrative) patient ability to measure and administer all agents prescribed for blood glucose management, including an objective or subjective characterization of patient visual acuity. Should also assess whether patient has previously received diabetes self-management education (within the last 6 months or at recent change in regimen).
If self-monitoring is ordered, assessment of patient ability to self-monitor blood glucose.	If currently utilized, clinical documentation characterizes patient ability to objectively monitor blood glucose (i.e. can appropriately manipulate the device), record and communicate results to providers as necessary.
Assessment of patient ability to self-identify and report signs/symptoms of hyper and hypoglycemia	Clinical documentation characterizes patient ability to recognize symptoms of hyper and hypoglycemia and to take appropriate responsive actions (e.g. glucose gel administration, etc.). Specific characterization of the presence or absence of hypoglycemia unawareness (symptom types, blood glucose thresholds) is preferred.
Provision of educational materials to patient	Patient education is a key component of quality diabetes management, particularly as patient's transition between care settings and experience changes in medical status, diet, and medications. Documentation of the provision of educational materials should be shared with subsequent providers. Details of the content of such materials is recommended, but not required.
Assessment of patient/caregiver understanding of the education	Clinical documentation should characterize patient comprehension of their diabetes-related care plan, including recommended diet, monitoring and symptom recognition, medication administration and adherence, and communication with healthcare providers.
If applicable, a post-discharge appointment should be scheduled with the diabetes management prescriber/ physician or endocrinologist	An appointment for subsequent provider follow-up should be scheduled within 7 days of discharge and documented.

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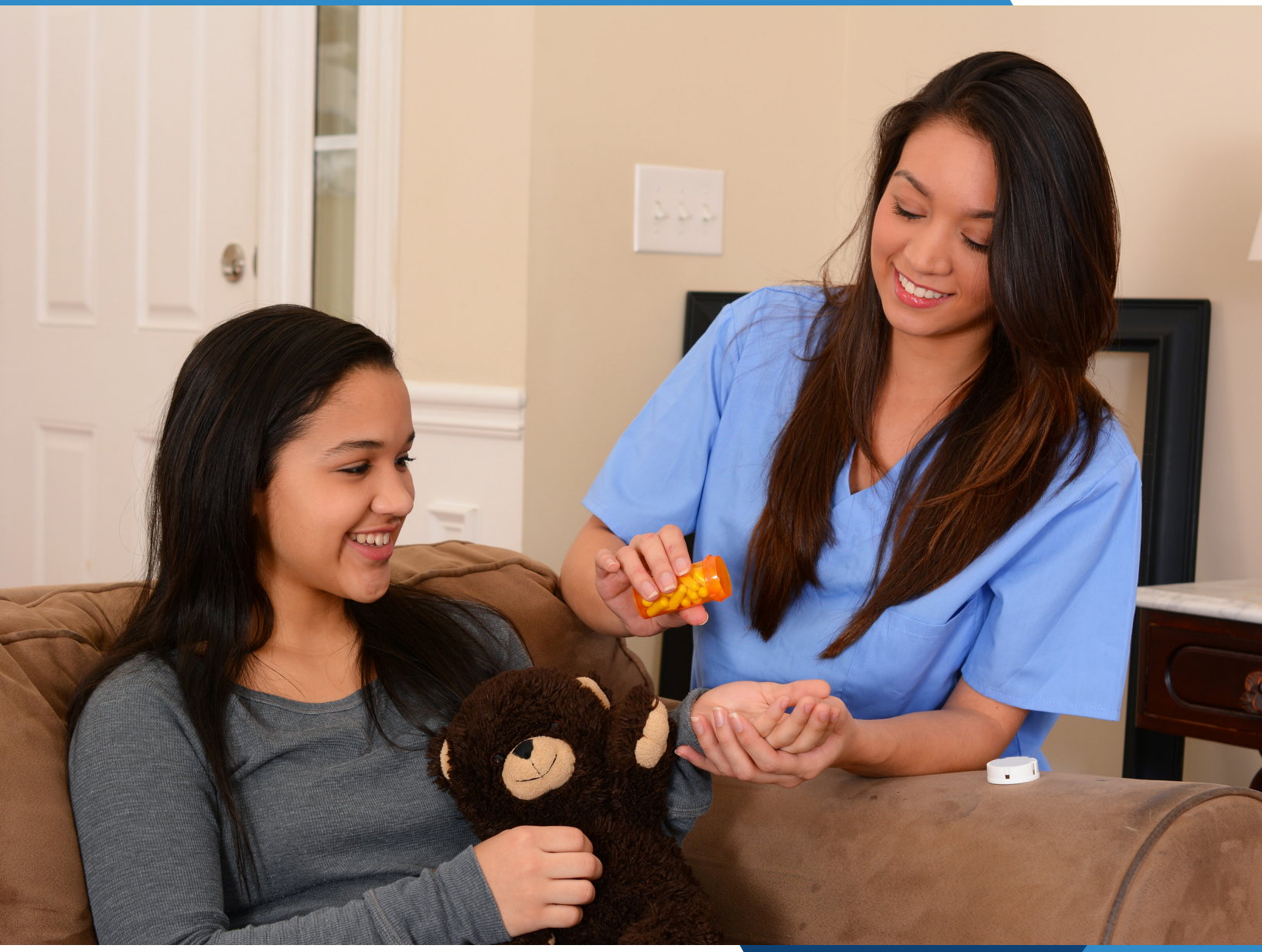
Diabetes Management

Diabetes diagnosis, including subtype classification	YES ☐ NO ☐
Duration of diabetes (new diagnosis or chronic)	YES ☐ NO ☐
Recent blood glucose values along with blood glucose monitoring schedule with date and time for when the next blood glucose value is due	YES ☐ NO ☐
Target range for blood glucose	YES ☐ NO ☐
History of hypoglycemic episodes	YES ☐ NO ☐
Current antihyperglycemic drug regimen	YES ☐ NO ☐
Recent changes in the antihyperglycemic drug regimen	YES ☐ NO ☐
Identification of and associated rationale for sliding scale insulin order initiated during hospitalization	YES ☐ NO ☐
Current diet including whether it is administered via enteral feeding tube and if so, the schedule should be provided	YES ☐ NO ☐
Age	YES ☐ NO ☐
Presence of surgical interventions or trauma/tissue damage	YES ☐ NO ☐
Presence of dementia	YES ☐ NO ☐
Presence of delirium if known	YES ☐ NO ☐
Last value and date of renal assessment	YES ☐ NO ☐
Current non-antihyperglycemic drug list	YES ☐ NO ☐
Details of systemic glucocorticoid therapy, if applicable	YES ☐ NO ☐
Assessment of patient ability to self-administer current diabetes regimen	YES ☐ NO ☐
If self-monitoring is ordered, assessment of patient ability to self-monitor blood glucose.	YES ☐ NO ☐
Assessment of patient ability to self-identify and report signs/symptoms of hyper and hypoglycemia	YES ☐ NO ☐
Provision of educational materials to patient	YES ☐ NO ☐
Assessment of patient/caregiver understanding of the education	YES ☐ NO ☐
If applicable, a post-discharge appointment should be scheduled with the diabetes management prescriber/ physician or endocrinologist	YES ☐ NO ☐



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