Transitions Champion Interview Checklist

To be completed by Transitions Champion with each patient who has had a hospital admission or ER visit within 24–48 hours of return to dialysis facility.

☐ **1. Call patient and have them bring all medication bottles in for review at first dialysis treatment post discharge. Ensure RN is notified that a medication review is required on first treatment back to facility.**

Points of Discussion:

a. Did you have any medications stopped or doses changed during hospitalization?

b. Did you have any new prescriptions given to you by the hospital/ER?

☐ **2. Talk with patient regarding follow-up visits.**

Points of Discussion:

a. What are the appointments for and with whom? When are the appointments?

b. If conflicts exist with your appointments and your dialysis schedule, either attempt to schedule your appointment around your dialysis or reschedule your dialysis around the time/day of appointment.

c. Will you have any trouble getting to this appointment? Can a family member attend with you?

☐ **3. Assess whether patient understands the reason for the hospitalization or ED Visit**

Points of Discussion:

a. Do you understand why you were admitted or the signs that the condition is reoccurring or worsens?

b. Who would you call if the condition worsens?

c. What can we work on together to prevent another hospitalization or ER visit for this condition?

Based on the information obtained from this interview, you may want to provide the patient with more tools and resources.

1. Provide a list of signs or symptoms to look for which signal condition is worsening.
2. Provide an updated medication list for them to take home.
3. Select a family member or close contact with permission to review items and assure followup appointment attendance.
4. Other education such as fluid management and potassium management may require other members of the interdisciplinary team (IDT) to assist.
5. Reinforce the rescheduling treatment process.
6. Document your discussion with the patient and mark the patient “unstable” in the care plan, to review their progress post-hospitalization and any need for IDT involvement.

Notes

IPRO End-Stage Renal Disease Network Program
Corporate Office: 1979 Marcus Avenue, Lake Success, NY 11042-1072 • Patient Services: (516) 231-9767
Data Management: (516) 268-6426 • Administration: (516) 686-9790
Customer Support Portal: help.esrd.ipro.org/support/home • Website: esrd.ipro.org
Toll-Free: (800) 238-3773 • Email: esrdnetworkprogram@ipro.us • Web: esrd.ipro.org

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End-Stage Renal Disease Network Program

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