

COVID-19 Care Coordination Script

This script contains probes specific to the management of COVID-19 patients. If you have care coordination software, consider adding COVID-19 specific probes and follow-up if you have not already done so.

COVID-19 positive patient

DCd from Inpatient OBS ED Ambulatory

Pt reported symptoms requiring immediate medical attn. (per Dignity Health Covid Care Guide)

Advised redirected to Emergency Dept/ call 911 Assisted with 911 call

Patient Name	DOB	Date of Admission	Date of Discharge
Click here to enter text.	9/11/2020	Click to enter date.	Click to enter date.
Patient Phone Number	Date of Post Hospital DC Call	Readmission History	
Click here to enter text.	Click for date. 1 <input type="checkbox"/> Attempt Click for date. 2 <input type="checkbox"/> Attempt Click for date. 3 <input type="checkbox"/> Attempt TCM call within Choose an item.	Within last 30 days? Yes <input type="checkbox"/> No <input type="checkbox"/> Reason(per pt) Click here to enter text.	
PCP			
Click here to enter text.			
Call made by	Spoke to :		
	Patient <input type="checkbox"/> Caregiver <input type="checkbox"/>		
DC Disposition	Caregiver/DPOA/Other support Name(s) <input type="checkbox"/> Click here to enter text.		
Discharge facility type: Choose an item.	Caregiver/DPOA Relationship <input type="checkbox"/> Click here to enter text.		
Facility Name <input type="checkbox"/> Click here to enter text.	Permission to speak to family member? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Discharge diagnosis: <input type="checkbox"/> Click here to enter text.	Consent to Amb CC Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Does pt have support sytem in place Yes <input type="checkbox"/> No <input type="checkbox"/>		

Appointments

- F/U Appt w/ PCP : Yes No Date of Appt Click here to enter a date. Time of Appt Click here to enter text.
- Have you had your annual wellness visit? Yes No Month/ year of last Click here to enter text.
- Specialist referrals? Yes No Date of Appt Click here to enter a date. Time of Appt Click here to enter text.
- Appointment assistance provided Yes No
- Does pt have transportation to make these appointments? Yes No
 - Transportation assistance provided Yes No

Other Resources	Ordered	Company	Date of Delivery/ Start of Service	Pt has contact info	Contact info or assistance provided
HH	Y <input type="checkbox"/> N <input type="checkbox"/>		Click here to enter a date.	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
DME	Y <input type="checkbox"/> N <input type="checkbox"/>		Click here to enter a date.	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Home O ₂ L/min	Y <input type="checkbox"/> N <input type="checkbox"/>		Click here to enter a date.	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Other (specify)	Y <input type="checkbox"/> N <input type="checkbox"/>		Click here to enter a date.	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Pt has pulse Pulse Ox?	Y <input type="checkbox"/> N <input type="checkbox"/>	Date/time last reading _____	%:	Covid care Guide Provided	Y <input type="checkbox"/> N <input type="checkbox"/>	Pulse Ox monitoring? Y <input type="checkbox"/> N <input type="checkbox"/>
Dischard with Incentive (IS)	Y <input type="checkbox"/> N <input type="checkbox"/>	Currently Using IS	Y <input type="checkbox"/> N <input type="checkbox"/>	IS guide provided	Y <input type="checkbox"/> N <input type="checkbox"/>	

Symptom (Δ since DC)	Breathing difficulty	Cough	Diarrhea	Fever	Nausea
Date:	Same <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Resolved <input type="checkbox"/>	Same <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Resolved <input type="checkbox"/>	Same <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Resolved <input type="checkbox"/>	Same <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Resolved <input type="checkbox"/>	Same <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Resolved <input type="checkbox"/>

Additional information/needs/barriers:

- Patient is currently enrolled in care coordination program Choose an item.
- Meets criteria for Care Coordination: Consented and referred/enrolled on Click here to enter a date.
- Meets criteria for Care Coordination: Choose an item. Declined on Click here to enter a date.