Care Transitions

Acute Care Provider Care Transitions Assessment

Facility Name: _____ **CCN:** _____ **Assessment Date:** _____ **Completed by:** _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Medication Management					
1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission.[i]	☐	☐	☐	☐	☐
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology.[ii]	☐	☐	☐	☐	☐
3. Your facility has a process in place to ensure patients can both access and afford prescribed medications prior to discharge (e.g., Meds-to-Beds, home delivery of meds, for affordability verification).[iii]	☐	☐	☐	☐	☐
B. Discharge Planning					
4. When patients meet high readmission-risk criteria, your facility focuses customized care coordination efforts for:[iv] **a.** Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.).	☐	☐	☐	☐	☐
b. Patient-centered care planning addressing potential transitional barriers (continual process customized for each unique patient focusing on optimal outcomes while including the patient and caregivers in decision making).[v]	☐	☐	☐	☐	☐

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
c. Complex care needs using intensive case management (provides access to specialized nurses and other resources [dietitian, clinical pharmacists, behavioral therapists] that can assist in better managing health and care coordination throughout the care continuum).	☐	☐	☐	☐	☐
5. Your facility manages super-utilizers (four admissions in one year—**or**—six emergency department visits within one year) using a customized case management approach that individualizes patient-centered care coordination plans.[vi]	☐	☐	☐	☐	☐
6. Your facility tracks and trends:[vii] **a.** Unmet needs (e.g., social determinates of health, undelivered durable medical equipment [DME], delay or non-arrival of home health services, etc.) of those who have been readmitted, to develop process improvement.	☐	☐	☐	☐	☐
b. Number of Medicare Fee-for-Service (FFS) and Medicare Advantage patients case managed beyond initial screening.	☐	☐	☐	☐	☐
c. Patients readmitted within seven days.	☐	☐	☐	☐	☐
C. Care Continuum					
7. Your facility uses a mechanism for bi-directional feedback with post-acute care partners to address transition communication gaps of key clinical information during transfers (e.g., discharge summary, outstanding tests/lab results, medication list discrepancies). [viii]	☐	☐	☐	☐	☐
8. Your facility has a mechanism in place to track and trend transitional care/support (e.g., dashboard): **a.** Patients who **received*** any post discharge follow-up intervention (e.g., phone call, telehealth, home health, community paramedics, transition-of-care clinic) within 48–72 hours post discharge. **Actually received rather than ordered.*	☐	☐	☐	☐	☐
b. Patients who followed up with a physician within seven days post-discharge.[ix]	☐	☐	☐	☐	☐
9. Your facility provides focused case management to link all high-risk patients to community support after discharge (e.g., community navigators, community health workers, telehealth services, etc.).[x]	☐	☐	☐	☐	☐

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
D. Facility Infrastructure					
10. Your facility maintains a multidisciplinary task force concentrating on improving care transitions with defined goals and structure.[xi]	☐	☐	☐	☐	☐
11. Your facility has an ongoing improvement project focused on increasing the percentage of patients who "strongly agree that they understood their care when they left the hospital," demonstrated by Hospital CAHPS® (Consumer Assessment of Healthcare Providers and System [HCAHPS]) scores.[xii]	☐	☐	☐	☐	☐
12. Your facility annually, at minimum, conducts a community inventory of available resources addressing pertinent health disparities within the community (e.g., community resource guide, #2-1-1, etc.).[xiii]	☐	☐	☐	☐	☐

Open Response:

1. **What do you believe is going well in your organization related to care transitions (please provide any tools or methodology you are using)?**

2. **Where are opportunities for improvement regarding care transitions?**

3. **What are your organizational goals for this calendar year surrounding care transitions?**

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-12092021-01

i **Rationale:** Medication reconciliation at admission, transfer, and discharge, increases patient safety and prevents unnecessary healthcare utilization. Pharmacist-led medication reconciliation programs are effective at reducing readmissions.
References: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1254
- https://pdfs.semanticscholar.org/d39d/5f713eb63237e43b461785c32124cdde9273.pdf
- https://bmjopen.bmj.com/content/bmjopen/6/2/e010003.full.pdf
- http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

ii **Rationale:** Evidence-based education methodologies (such as teach-back) can increase patients'/caregivers' recall of side effects and purpose of new medications. Pharmacy education has been shown to improve compliance and enhance patient understanding.
References: http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf

iii **Rationale:** Cost-related non-adherence among older adults has been documented as a significant problem in care coordination. Organizations should integrate an affordability analysis and insurance verification process in the discharge plan to address this barrier.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780603/
- https://drc.bmj.com/content/bmjdrc/6/1/e000460.full.pdf
- https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

iv **Rationale:** Focusing increased transitional intervention for those identified as high risk for readmission based on associated factors reduces probability for subsequent rehospitalization. Causes of readmissions are often related to unmet social factors which impact an individual's health.
References: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
- http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5018668/
- https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
- **Intervention Resource Table:** https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

v **Rationale:** Addressing gaps in patient and caregiver preparedness during hospitalization is crucial to mitigate barriers and invoke confidence in a safe and appropriate plan of care prior to discharge.
References: http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
- https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf

vi **Rationale:** Admission patterns can be used to predict the likelihood of a readmission. Identifying super-utilizers and customizing patient-centered care plans through an intensive case management approach can reduce utilization and readmission risk for this complex population.
References: https://www.chcs.org/media/FINAL_Super-Utilizer_Report.pdf
- https://www.ncbi.nlm.nih.gov/pubmed/31270786
- https://www.ncbi.nlm.nih.gov/pubmed/29461853

vii **Rationale**: Determining the cause of readmission will illicit gaps in care that patients are experiencing. Organizations need to use this information to improve care transition practices and delivery of care by developing process improvement projects surrounding their findings.

Reference: https://repository.usfca.edu/cgi/viewcontent.cgi?referer=https://scholar.google.com/&httpsredir=1&article=1439&context=capstone
- https://drc.bmj.com/content/6/1/e000460?cpetoc
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6522678/

viii **Rationale:** Readmission rates are usually the highest from SNFs (approximately 25 percent). Building and maintaining a successful partnership with post-acute providers requires effective communication, collaboration, and commitment to reduce readmissions and improve patient outcomes.
References: http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf

ix **Rationale:** Readmission to the hospital within seven days of discharge is common and many of those readmissions can be attributed to failures in post-discharge communication, planning, and follow-up.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128446/

x **Rationale:** Developing and sharing a customized patient-centered care plan for high-risk/high-need patients identifies the support and resources they need once they leave the hospital.
References: https://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf
- https://camdenhealth.org/

xi **Rationale:** Assessment and management of high-risk patients is a complex, multi-process, multi-role activity that requires consistent systemic vigilance, evaluation, and communication across care units and settings. A multidisciplinary task force establishes shared responsibility and opens lines of communication.
References: http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf

xii **Rationale:** Enhancing patient activation and engagement in decision-making increases patient and family participation, ownership, and empowerment of a treatment and discharge plan; initiating education upon admission prepares the patient and/or family to care for his or her condition prior to discharge.
References: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
- https://caretransitions.org/wp-content/uploads/2016/02/Family-caregivers%E2%80%99-experiences-during-transitions-out-of-the-hospital.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5734517/
- https://www.ncbi.nlm.nih.gov/pubmed/29395026
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3912296/

xiii **Rationale:** A patient's ZIP Code is more important than his or her genetic code as it relates to health outcomes. Identifying clinical, behavioral, and social service resources in the community effectively—and linking patients to the services they need once they leave the hospital—is essential to ensure optimal health.
References: http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html
- https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool11_comm_resource.docx
- https://www.cmsqualityconference.com/