Transitions of Care Planning Guide: Key Elements Worksheet

Use this fillable worksheet of key elements from the Transitions of Care Planning Guide to create and execute a strategy for collaborating with other providers to identify the barriers to smooth transitions and to identify, implement, and evaluate collective solutions.

1. Client Intake and Risk Assessment

	Element	Status	Responsible	Timeline
1.1	Establish a risk assessment process as part of client intake.	Completed	n/a	n/a
1.2	Develop care pathways based on risk score/level and client needs.	Completed	n/a	n/a
1.3	Document the client's risk score and identified risks in the discharge/appointment summary.	In Progress	Jane Doe	6/15/18
1.4	Obtain care plan from other involved providers; reinforce and revise the care plan, as necessary.	Partial	John Smith	6/15/18
1.5	Implement method(s) to notify other providers and share medical records, including reasons service/admission, including (as appropriate): 1.5.1 PCPs 1.5.2 Outpatient behavioral health providers 1.5.3 Other medical specialists 1.5.4 Health Home providers			
1.6	Investigate and implement as appropriate a process to receive alerts via the Qualified Entity in your region when your client is admitted or discharged from an inpatient facility or the ER.			
1.7	Establish an organizational workflow for clients without an established PCP and/or behavioral health provider.			

Communications@TheNationalCouncil.org | 202.684.7457 | 1400 K St., NW, Suite 400, Washington, DC 20005

2. Care Plans

	Element	Status	Responsible	Timeline
2.1	Obtain the client's care plan from the other providers if a care plan already exists.			
2.2	Create a shareable care plan that includes client's risk level to be sent to other providers involved in the client's care.			
2.3	Involve the client and family in creating and updating the care plan.			
2.4	Ensure that the care plan is accessible for all care providers using an agreed-upon electronic or (if necessary, manual) process.			

3. Medication Reconciliation

	Element	Status	Responsible	Timeline
3.1	As an organization, create a standard process for reconciling clients' medications upon admission/intake, and upon discharge home or transfer to another care setting (including another inpatient unit).			
3.2	Prior to transition, review the reconciled medication list with the client/caregiver. Offer a simple and easy-to-follow medication list tool to the clients.			
3.3	Include referral to home health services in care pathway for medication management support for clients unable to understand or manage his/her medications.			
3.4	Provide the medication list to the primary care/behavioral health provider and the client/caregiver and include in the client's discharge/appointment summary and care plan.			
3.5	During follow-up phone calls (see Section 8 of the Transitions of Care Guide) after a transition, provide the client/caregiver an opportunity to ask questions about taking his/her medications.			

Communications@TheNationalCouncil.org | 202.684.7457 | 1400 K St., NW, Suite 400, Washington, DC 20005

4. Social/Resource Barriers Assessment and Links to CBOs

	Element	Status	Responsible	Timeline
4.1	Incorporate social service and non-medical needs as part of the organization's assessment of the client's barriers to services (see element 1.1).			
4.2	Create an inventory of community resources that can be tailored to the client's needs.			
4.3	Include a process to connect clients to local CBOs in your care pathways.			
4.4	Establish a "feedback loop" with CBOs to determine whether clients received services and the outcomes of those services.			

5. Client and Family Engagement

	Element	Status	Responsible	Timeline
5.1	Create a plan to implement a client and family engagement strategy in your organization.			
5.2	Incorporate approaches to achieve cultural competency, considering the social, linguistic, and cultural characteristics of clients and families.			
5.3	Obtain and document client/family communication preferences including mode (phone, text, email), language, and alternate contacts.			
5.4	Establish a client/family advisory body or other mechanism to elicit and respond to needs expressed			
5.5	Conduct client/family satisfaction surveys at regular intervals.			

6. Scheduling the "Follow-up" Appointment and Other In-Person Future Contacts

	Element	Status	Responsible	Timeline
6.1	For clients being referred to another community provider, schedule the follow-up appointment while the client is on site.			
6.2	Ask about and address client and family barriers to attending the follow-up appointment(s) (e.g., transportation, financial issues, language, etc.).			

6.3	Document the follow-up appointment details in the care plan and attach any relevant tests.			
6.4	Provide practical information to client and/or family about the next appointment, and provide documentation of this, as appropriate.			

7. Client Handover

	Element	Status	Responsible	Timeline
7.1	Establish care pathway for transitioning clients to other settings, taking into account client's level of risk.			
7.2	Complete a discharge summary/care plan			
7.3	Establish processes to ensure that providers receive discharge summary/care plan within 24-48 hours of the transition or prior to scheduled follow-up appointment.			
7.4	Provide the client/family a copy of the care plan instructions with details how to follow-up if they have questions.			

8. Follow-up Phone Call or Other Remote Contact

	Element	Status	Responsible	Timeline
8.1	Place reminder calls to clients prior to upcoming visit using information about communication preferences established in element 5.3 above.			
8.2	Develop a process to connect clients/families with appropriate provider in case a client/caregiver has specific questions.			
8.3	Add FAQs, contact information, and other relevant instructional information to the organization's website and direct clients there as appropriate			

9. Follow-up Appointment

	Element	Status	Responsible	Timeline
9.1	Allow sufficient appointment time for a thorough examination and to address post-discharge (if applicable) follow-up items including access to medication.			
9.2	Engage clients in goal setting and shared decision making.			

9.3	Provide opportunities for the client/caregiver to ask questions.			
9.4	Utilize a checklist/assessment to ensure that all needed follow-up conversations and services occur.			
9.5	Schedule any future/follow-up appointments as appropriate following elements in Section 6 of the Transitions of Care Planning Guide.			
9.6	Establish a process to inform the referring provider of the outcome of the visit.			

10. Feedback for Quality Improvement

Element		Status	Responsible	Timeline
10.1	Identify SMART goals for improving transitions of care in your organization.			
10.2	Establish a system/mechanism to measure performance based on identified SMART goals; specify data sources and who is responsible for collecting, reporting and reviewing the data collected.			
10.3	Systematically review a random sample of readmission cases for quality improvement purposes.			
10.4	Create a forum between hospitals, community providers, clients and their families to review the feedback together and establish process to improve transitions of care.			
10.5	Implement changes to the transitions of care processes based on feedback and performance on identified metrics.			

Communications@TheNationalCouncil.org | 202.684.7457 | 1400 K St., NW, Suite 400, Washington, DC 20005