Qualis Health

# Care Transitions Assessment

## The purpose of this tool is to help hospitals:

- Assess the organization's current activity related to care transitions and avoidable rehospitalizations
- Identify opportunities for improvement
- Measure progress over time

## How to improve your score

**Once the assessment is complete, your team should:**

- Brainstorm what it would take to move up a level—for a particular component, a section of the assessment, or your hospital's score overall.
- Plan tests (PDSA cycles) for those process changes that your team believes will result in improvements. See www.Medicare.QualisHealth.org/PDSA for instructions.

**Not sure what changes to make? Want to see the evidence base behind a particular intervention?**

- See www.Medicare.QualisHealth.org/TransitionTools for resources
- Contact Qualis Health for assistance. See www.Medicare.QualisHealth.org/CTcontacts for our team's information.

*Keep at it! Continue testing and adapting activities until your scores reach the A level.*

## Recommended process

**Gather a team**

This assessment will provide the greatest value when completed by a team of individuals representing a range of roles, such as:

- Physicians and nurses from several units (ED, surgery, hospitalists, etc.)
- Social workers
- Case managers
- Discharge coordinators
- Home care referral coordinators
- Pharmacists
- All members of the hospital's readmissions QI team

**Reach consensus**

We recommend that team members complete the assessment individually, then meet as a group to discuss the results and produce a consensus version.

We discourage simply averaging the members' scores. **The consensus-reaching discussion is part of the benefit of the assessment** and may reveal previously unrecognized variation and opportunities for improvement.

**Repeat**

For maximum value, complete the assessment at least twice—with a minimum of six months between assessments. The first time documents your baseline score and subsequent assessments show progress over time.

## Instructions for using the form

You will be rating your hospital on 33 individual elements, each of which is described in four stages of implementation (Level D = none or minimal and Level A = fully developed). Please note that in some cases, parts of the description may be very similar across levels; phrases with identical wording are shown in a colored font. Within each implementation stage are three possible scores to indicate that progress is just beginning, underway, or well established.

For each component, please select the number that most accurately reflects your current situation.

The assessment may be completed:

- Electronically, by clicking into the "Score" field for each component starting on page 5 and typing the appropriate number (1–12). The results will automatically transfer to the Score Card on page 4. You will need Adobe Acrobat or Adobe Reader to complete the assessment electronically. Adobe Acrobat can be downloaded for free at https://get.adobe.com/reader/
- By hand, writing in the appropriate scores and performing the page 4 calculations yourself.

Bring a copy of your completed Score Card to the team meeting for further discussion.

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# Score Card

| Overall Total | Overall Score (÷7) |
|---|---|
| 0 | 0.0 |

If you are completing the Assessment electronically, the scores you enter starting on page 5 will be automatically transferred here.

If you are completing the Assessment on paper, please transfer your scores for each component to the corresponding space below, then calculate the totals and averages.

Bring your completed Score Card to your team meeting.

## Building the Foundation

### 1. Engaged Leadership

| | | Section Total | Section Avg (÷4) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |
| D | | | |

### 2. Change Management Through Data

| | | Section Total | Section Avg (÷5) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |
| D | | | |
| E | | | |

### 3. Quality Improvement Strategy

| | | Section Total | Section Avg (÷4) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |
| D | | | |

## Standardization

### 4. Standard Process

| | | Section Total | Section Avg (÷5) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |
| D | | | |
| E | | | |

### 5. Information Transfer

| | | Section Total | Section Avg (÷6) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |
| D | | | |
| E | | | |
| F | | | |

## Focus on the Patient

### 6. Patient Activation

| | | Section Total | Section Avg (÷3) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |

### 7. Care Continuum Coordination

| | | Section Total | Section Avg (÷6) |
|---|---|---|---|
| A | | 0 | 0 |
| B | | | |
| C | | | |
| D | | | |
| E | | | |
| F | | | |

## *Part 1: Engaged Leadership*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. Executive leaders<br><br>Score _____ | …are focused on short-term business priorities. | …verbally support care transitions improvement, but do not commit resources. | …allocate resources and actively sustain care transitions improvement initiatives. | …support continuous care transitions learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement, and spread care transitions QI initiatives. |
| B. Clinical leaders<br><br>Score _____ | …intermittently focus on improving patient experience and clinical outcomes during care transitions. | …have developed a vision for improving patient experience and clinical outcomes during care transitions, but no consistent process for getting there. | …are committed to a process to improve patient experience and clinical outcomes during care transitions, and sometimes engage teams in implementation and problem solving. | …consistently champion and engage clinical teams in improving patient experience and clinical outcomes during care transitions. |

## *Part 1: Engaged Leadership, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. The organization's hiring and training processes<br><br>Score _____ | …focus specifically on the narrowly defined functions and requirements of each position. | …reflect how potential hires will affect the organizational patient-centered culture. | …place a priority on the ability to manage care transitions and create a patient-centered culture, including his/her ability to provide culturally competent care. | …place a priority on the ability to manage care transitions and create a patient-centered culture, including his/her ability to provide culturally competent care; support and sustain improvements through training and incentives related to providing patient-centered and culturally competent care. |
| D. The responsibility for conducting care transitions QI activities<br><br>Score _____ | …is not assigned by leadership to any specific individual or group. | …is assigned to an individual or group without committed resources. | …is assigned to an individual or organized QI group who receives sufficient dedicated resources. | …is shared throughout the organization, from the QI Department and leadership to frontline staff, and is made explicit through protected time to meet and specific resources to engage in QI for care transitions. |

## *Part 2: Change Management Through Data*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. The readmissions QI team<br><br>Score _____ | …rarely uses data to guide choices or track progress. | …uses outcome metrics to track progress, but rarely uses data to inform intervention choices. | …has drilled down on hospital-specific data and uses this data to target interventions.<br>Does not routinely track process measures related to interventions. | …has an identified QI methodology and a systematic approach to data, allowing it to create and review pertinent reports that guide and track the effectiveness of interventions over time. |
| B. Root cause analyses related to care transitions and readmissions<br><br>Score _____ | …are non-existent,<br>or<br>…are limited to determining trends in readmissions by unit or service line/diagnosis.<br>Attempts are rarely made to identify the root causes of identified trends. | …are done in a non-uniform and/or unsystematic manner.<br>Responses to findings are rarely implemented. | …are done systematically to understand population trends and/or individual reasons for readmission/discharge failure, but are inconsistent in the types of information reviewed.<br>May involve collection and analysis of race, ethnicity, and language data.<br>Responses to findings are variable. | …are done systematically to understand population trends and/or individual reasons for readmission/discharge failure, using articulated processes for the collection and analysis of information, at both overview and granular levels.<br>Involves collection and analysis of race, ethnicity, and language data.<br>Findings are consistently used to identify opportunities for improvement and guide interventions. |

## *Part 2: Change Management Through Data, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. Data results related to care transition processes and readmissions outcomes<br><br>Score _____ | …are locally owned by separate clinical teams/ departments and are often not compiled in a meaningful way.<br>There is no process for sharing the data with appropriate stakeholders. | …are compiled as data are available, and are regularly presented to readmissions QI team members.<br>No specified processes exist to convey appropriate data to leadership or frontline staff. | …are compiled centrally and data may be drilled down to the unit level.<br>Analytic staff have workflows to share data proactively with readmissions QI team members.<br>Processes exist to convey data to leadership but there is no standard process for sharing with frontline staff. | …are compiled centrally; data are drilled down and clearly displayed at the unit level.<br>Analytic staff have workflows to share data proactively with readmissions QI team members.<br>Processes exist to clearly identify which data are to be reviewed by leaders, managers, frontline staff, and possibly patients. Data are acted upon at all levels. |

## *Part 2: Change Management Through Data, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| D. Data about readmitted patients<br><br>Score _____ | *Quantitative data*<br>…are collected from claims or chart reviews on a retrospective, project-request basis.<br><br>*Qualitative data*<br>…are not collected. | *Quantitative data*<br>…are regularly and systematically collected from claims or chart reviews and reviewed by the readmissions QI team.<br><br>*Qualitative data*<br>…are not collected. | *Quantitative data*<br>…are regularly and systematically collected from claims or chart reviews and reviewed by the readmissions QI team.<br><br>*Qualitative data*<br>…are occasionally collected via patient/family interviews or focus groups.<br>Information gathered in this way is occasionally shared with key stakeholders including providers, but there is no reliable process for compiling, or identifying trends from, qualitative data. | *Quantitative data*<br>…are regularly and systematically collected from claims or chart reviews and reviewed by the readmissions QI team.<br>Additionally, data are collected in real time—via clearly articulated workflows— to identify newly admitted patients who were also admitted within the previous 30 days.<br><br>*Qualitative data*<br>…are systematically collected via structured interviews with patients/families.<br><br>*Both quantitative and qualitative data*<br>Processes are defined to analyze data, identify trends, and share with key stakeholders (including providers) at least weekly. |

## *Part 2: Change Management Through Data, continued*

| **Component** | **Level D** *(Score: 1-3)* | **Level C** *(Score: 4-6)* | **Level B** *(Score: 7-9)* | **Level A** *(Score: 10-12)* |
|---|---|---|---|---|
| E. Hospital data analysts<br><br>Score _____ | …are centrally located and, depending on capacity, respond to varying tasks upon request. | ….are centrally located and are occasionally assigned to support activities of the readmissions QI team or specific workgroups longitudinally. | …work in either a central or distributed team, often working longitudinally with, and functioning as members of, the readmissions QI team or specific workgroups. | …are closely associated with the readmissions QI team and assigned workgroups, regularly attend team meetings, lead in interpretation of data, and suggest additional analyses and reports. |

## *Part 3: Quality Improvement (QI) Strategy Data*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. QI activities related to care transitions<br><br>Score _____ | …are not organized or consistently supported. | …are conducted on an ad-hoc basis in reaction to specific care transitions/readmissions problems. | …are based on a formally adopted improvement strategy in reaction to specific care transitions/readmissions problems. | …are based on a formally adopted improvement strategy and used continuously in meeting care transition goals. |
| B. Performance measures related to care transition process changes and readmissions outcomes<br><br>Score _____ | …are limited to general readmission rates that are not drilled-down to provide a comprehensive picture. | …are comprehensive, including drilled-down readmission rates *(i.e. by unit, specialty, diagnosis, payer, race, ethnicity, language, etc.)* as well as patient experience measures related to discharge processes.<br>Results are not shared with frontline staff or individual providers. | …are comprehensive, including drilled-down readmission rates *(i.e. by unit, specialty, diagnosis, payer, race, ethnicity, language, etc.)* as well as patient experience measures related to discharge processes.<br>Process measures are also tracked and used to inform intervention progress.<br>Occasionally, results are shared with frontline staff or individual providers. | …are comprehensive, including drilled-down readmission rates *(i.e. by unit, specialty, diagnosis, payer, race, ethnicity, language, etc.)* as well as patient experience measures related to discharge processes.<br>Process measures are also tracked and used to inform intervention progress.<br>Standard processes exist to regularly share results with frontline staff and individual providers. |

## *Part 3: Quality Improvement (QI) Strategy Data, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. QI activities related to care transitions are conducted by<br><br>Score _____ | …no one, on a proactive basis.<br>An individual or centralized group may conduct activities in response to specific problems that arise. | …separate individual(s) and/or group(s) without knowledge/ coordination of each other's efforts. | …topic-specific care transitions workgroup(s), supported by a QI infrastructure in which efforts are coordinated and prioritized.<br>Processes exist to regularly monitor and report progress of all care transition interventions. | …departments or units, with meaningful involvement of patients and families, supported by a QI infrastructure in which efforts are coordinated and prioritized.<br>Processes exist to regularly monitor and report progress of all care transition interventions. |
| D. An EHR that supports QI related to care transitions<br><br>Score _____ | …is not present. | …is being implemented or is in place, but is not being used to capture demographic and clinical data to drive QI efforts related to care transitions. | …is used routinely to capture demographic and clinical data to drive QI efforts related to care transitions. | …is used routinely to capture demographic and clinical data to drive QI efforts related to care transitions.<br>Additionally, the EHR provides interactive prompts based on an assessment of readmissions risk. |

## *Part 4: Standard Process*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. Readmission risk assessment<br><br>Score _____ | …is not completed; patients at increased risk of readmission are not identified upon admission. | …is not a standardized tool; admitting clinicians use a wide variety of methods to collect risk information with variable follow-up given the findings. | …is a standardized tool completed on admission; risk level is documented in patient record per procedure but does not reliably activate a response given the level of risk identified. | …is a standardized tool completed on admission that reliably activates a response given the level of risk identified.<br>Results are clear to all members of the patient's hospital team; efforts are made to build on this information and ensure a timely identification and arrangement of all post-hospital needs. |
| B. Identification of post-hospital medical and social needs<br><br>Score _____ | …does not consistently occur.<br>No standard process exists to identify and meet all post-hospital needs and address barriers to the patient's ability to secure and engage in the intended care plan. | …does not occur in a timely manner.<br>A standard process exists but typically leads to identification at or near the time of discharge, and in turn, the ordering of needed medical and social support services occurs late in the hospital stay or not at all. | …occurs through an early and ongoing assessment of medical needs and psychosocial factors to determine whether a home or community-based care setting is indicated; the timing and type of follow-up care, specialty care, and equipment required; and which additional community-based support services might be needed (*e.g. Meals on Wheels, transportation, prescription assistance, etc.*).<br>An individualized discharge plan is developed.<br>There is no reliable system to track timeliness of ordering/provision of needed services and equipment. | A reliable system exists to ensure the timely ordering and provision of needed services and equipment.<br>Whenever possible, family caregiver(s) are involved as full partners in determining the patient's post-hospital needs.<br>Whenever possible, the patient's PCP and other relevant community providers are contacted and asked to provide pertinent information and insight into home-going needs.<br>Patient preferences related to follow-up providers and services are identified (*i.e. gender, location, date, time, etc.*). |

## *Part 4: Standard Process, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. Palliative and hospice referrals<br><br>Score _____ | …are not routinely made as there is no palliative care consultation resource or process to trigger palliative care consultation or hospice referrals. | …are variable and informal based on condition, provider, social worker, and hospital unit. | ….are based on assessment criteria with a consultation/ referral process but variation exists in completing assessments and triggering timely referrals. | …are based on fully implemented assessment criteria and standard processes to trigger timely referrals. |
| D. Medication reconciliation is conducted<br><br>Score _____ | …out of the line-of-sight of frontline staff.<br>Two or more "final" medication lists may remain in the chart at discharge.<br>At discharge, frontline staff review each medication with patients/families rarely, if ever. | …out of the line-of-sight of frontline staff.<br>Two or more "final" medication lists may remain in the chart at discharge.<br>At discharge, frontline staff review each medication with patients/families consistently. | …in conjunction with frontline staff, at discharge.<br>There is a single medication list.<br>At discharge, frontline staff review each medication with patients/families consistently. | …in conjunction with frontline staff, at admission, at all handovers during the stay, and at discharge.<br>There is a single medication list.<br>At discharge, frontline staff review each medication with patients/families systematically using Teach Back.<br>The team assesses patient's intention and ability to obtain/ take medications and acts upon this information. |

## *Part 4: Standard Process, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| E. The discharge process at the hospital<br><br>Score _____ | …is highly variable and depends on the individual clinician(s) conducting the discharge. | …involves a checklist that is mostly procedural *(e.g., patient has his/her belongings)* and is not reliably used. | …follows a checklist, but:<br>• Only for patients cared for by hospitalists<br>• Use is rarely monitored<br><br>Checklist includes many of the following:<br>• Post-acute care *(e.g. appropriate setting, follow-up appointments, tests/ labs, etc.)*, medical equipment, and needed social support services are planned and scheduled with patient input.<br>• Correct medicines are identified and a plan is in place to obtain them.<br>• Teach Back is used to educate patient/caregiver on: a written discharge plan that patient/caregiver can understand, diagnosis, medicines, and what to do if a problem arises.<br>• Discharge summary is expedited to post-acute provider(s).<br>• Patient/caregiver is provided a 24/7 phone number on discharging floor for questions or concerns post-discharge.<br>• Patient/caregiver is called within 3 days of discharge to reinforce discharge plan and help with problem solving. | …always follows a checklist:<br>• Frontline staff can articulate the steps in the checklist<br>• Use is monitored<br><br>Checklist includes all of the following: |

## *Part 5: Information Transfer*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. Internal multidisciplinary *(e.g. MDs, RNs, social worker, case manager, discharge planner, pharmacist, etc.)* communication regarding post-acute care needs and discharge plan<br><br>Score _____ | *For all patients*<br>…is minimal or non-existent; team members develop their piece of discharge plan individually. | *For all patients*<br>…is generally limited to the transfer of information through documentation in patients' medical records. | *For high-risk patients*<br>…occurs as direct verbal communication.<br><br>*For all other patients*<br>…is generally limited to the transfer of information through documentation in patients' medical records. | *For all patients*<br>…begins on admisson and is an ongoing collaboration among the full multidisciplinary team to comprehensively assess and plan for patients' post-hospital needs. |
| B. POLST and advanced care planning information<br><br>Score _____ | ….are established for fewer than 50% of patients.<br>No standard process exists to ensure inclusion of this information in discharge documentation. | …are established for more than 50% of patients.<br>Documentation is consistently sent only for patients discharged to SNFs. | …are established for at least 80% of patients.<br>Documentation is sent to the next care setting. | …are established for at least 80% of patients.<br>Workflows are established to ensure transmission to next care setting, and transmission compliance rate is tracked. |

## *Part 5: Information Transfer, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. Health information technology<br><br>Score _____ | …plays no role in transfer of information between providers. | …is used as a one-way mode of communication between hospital and post-acute providers. | …includes two-way communication between hospital and post-acute providers. | …is implemented as a two-way system of communication, with automated alerts to PCP and other identified ancillary providers *(e.g. case managers, dialysis facilities)* for periodic updates and notices of admission or discharge. |
| D. Discharge communications with patient and/or caregiver<br><br>Score _____ | …usually occur at the point of discharge.<br>The method and format are variable. | …begin at admission.<br>The method and format are variable. | …begin at admission.<br>Some elements are standardized.<br>Occasionally use evidence-based methods *(e.g., Teach Back, Ask Me 3)* to assess and support patient understanding.<br>Interpretation services are used if appropriate.<br>All patients/caregivers leave the hospital with printed reminders of key aspects of their post-hospital care plan to use as a reference. | …begin at admission.<br>Some elements are standardized.<br>Consistently use evidence-based methods *(e.g., Teach Back, Ask Me 3)* to assess and support patient understanding.<br>Interpretation services are used if appropriate.<br>All patients/caregivers leave the hospital with printed reminders of key aspects of their post-hospital care plan to use as a reference.<br>These materials include only necessary content; in a simple, legible format appropriate to language and reading level.<br>Patient is called within 3 days to reinforce discharge plan. |

## *Part 5: Information Transfer, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| E. Communication with outpatient providers *(e.g. PCP, case manager, specialists)*<br><br>Score _____ | …occurs upon request of the outpatient provider only.<br>Content includes just the discharge summary and does not vary by risk of readmission. | …occurs per hospital procedure, but not within a consistent time frame.<br>Content includes just the discharge summary and does not vary by risk of readmission. | …occurs prior to patients' first follow-up visit.<br>Content and mode of communication vary depending on personal opinion, rather than in response to the systematic identification, of a patient's readmission risk. | …occurs prior to patients' first follow-up visit.<br>Content and mode of communication vary as directed by the systematic identification of patient readmission risk. |
| F. Communication with post-acute care settings *(e.g. SNF, home health)*<br><br>Score _____ | …is variable in content and manner of transmission. | …is accomplished by giving the paperwork to the patient/ caregiver, who is instructed to bring it to the post-acute setting.<br>Content includes the discharge notes, and the discharge summary may follow. | …is accomplished via a standard practice of faxing, mailing, or e-communicating.<br>Content includes the discharge orders and med list, followed by the discharge summary. | …is accomplished via a mutually agreed-upon manner of transmission.<br>High-risk transfers also utilize a voice-to-voice handover.<br>Content includes mutually agreed-upon standard elements; the discharge summary follows within 24 hours. |

## *Part 6: Patient Activation*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. Health literacy techniques (e.g., Teach Back, Ask Me 3)<br><br>Score _____ | …are not taught to staff.<br>Use of these techniques in patient teaching is inconsistent. | …are taught to some clinical staff.<br>There is no process to audit consistent use of techniques in patient teaching. | …are taught in initial orientation and at recurring intervals to staff across multiple disciplines.<br>A culture of consistent use of health literacy techniques is developing. | …are taught—including cultural components—in initial orientation and at recurring intervals to all staff interacting with patients.<br>There is consistent use of health literacy techniques in patient/caregiver interactions, especially at discharge.<br>Staff customizes discharge teaching to patient activation level. |
| B. Assessment of patient activation *(skills and confidence to carry out self-management activities)*<br><br>Score _____ | …does not occur. | …occurs inconsistently (no standardized timing or tool). | …occurs upon admission using a standardized tool.<br>Activation level is documented. | …occurs upon admission using a standardized tool.<br>Activation level is documented.<br>Results are reliably conveyed to appropriate follow-on staff; teaching and appropriate support services are provided to patient and/or family caregiver in response to assessed abilities. |

## *Part 6: Patient Activation, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. Teaching at discharge<br><br>Score _____ | …is inconsistent in content and timing. | …is provided just prior to discharge.<br><br>Standardized materials/ scripts may be used to teach medication management and "red flag" symptoms. | …is provided just prior to discharge; however, elements may be discussed earlier in the hospitalization.<br><br>Standardized materials/scripts are used to teach medication management and "red flag" symptoms. Instruction is provided on what to do/who to call if a problem arises.<br><br>Inconsistent use of Teach Back to confirm the patient's/ caregiver's understanding of diagnosis; prognosis; self-care requirements including medication management; symptoms of complications requiring immediate medical attention; and date, time and location of follow-up appointments.<br><br>Current use of a personal health record is assessed; instruction is provided using a sample paper copy. | …is provided just prior to discharge, but occurs throughout the hospitalization for repetition and reinforcement. Processes are in place to identify key family caregiver(s) and ensure their active engagement in discharge teaching.<br><br>Standardized materials/scripts are used to teach medication management and "red flag" symptoms, with customization according to the patient's/ caregiver's activation level. Instruction is provided on what to do/who to call if a problem arises.<br><br>Consistent use of Teach Back to confirm the patient's/ caregiver's understanding of diagnosis; prognosis; self-care requirements including medication management; symptoms of complications requiring immediate medical attention; and date, time and location of follow-up appointments.<br><br>Current use of a personal health record is assessed; instruction is provided using a sample paper copy. May include an EHR patient portal introduction. |

## *Part 7: Care Continuum Coordination*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| A. Admitting clinicians<br><br>Score _____ | …do not collect or verify information about PCP upon admission.<br><br>Do not collect or verify information about case managers upon admission. | …collect, but do not routinely verify, information about PCP upon admission.<br><br>Do not seek information about case managers. However, it may be obtained retroactively via discharge planning screening or receiving call from case manager.<br><br>Admit communication with PCP and any known case managers is random or for high-risk patients only. | …collect and verify information about PCP upon admission.<br><br>Seek information about case managers for managed care and dialysis patients; for other patients, this information may be obtained retroactively via discharge planning screening or receiving call from case manager.<br><br>Admit communication with PCP takes place consistently, but may not routinely notify case manager. | …routinely collect and verify information about PCP upon admission.<br><br>Routinely collect and verify accuracy information about case managers upon admission.<br><br>Admit communication with PCP and case manager takes place consistently. |
| B. Discharging clinicians<br><br>Score _____ | …do not communicate with PCP/any case managers. | …communicate with PCP/any case managers at discharge inconsistently. | …communicate with PCP/any case managers at discharge inconsistently, or for high-risk patients only.<br><br>May assist high-risk patients in scheduling follow-up with their PCP, and establishing a PCP if patient does not have one. | …communicate with PCP/any case managers prior to discharge to coordinate treatment plan, notify of discharge, and convey pertinent information.<br><br>Assist all patients in scheduling follow-up with their PCP, and establishing a PCP if patient does not have one. |

## *Part 7: Care Continuum Coordination, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| C. Readmissions QI team<br><br>Score _____ | …addresses transition issues only when a significant problem occurs with a specific transfer to or from the ED or inpatient setting. | …has regular contact with referral partners that tend to be of a marketing nature or based on the hospital's need to ensure post-acute referral resources for specific types of patients *(i.e. bariatric, ventilator)* or after hours/ weekend transfers. | ...has a structure in place to regularly meet at least quarterly with groups of high volume post-acute providers *(i.e. SNFs and HHAs)* to identify and improve processes for transfers from the post-acute provider to the hospital setting and hospital to post-acute provider settings. | ...has a structure in place to regularly meet at least quarterly with groups of high volume post-acute providers *(i.e. SNFs and HHAs)* to identify and improve processes for transfers from the post-acute provider to the hospital setting and hospital to post-acute provider settings.<br>Has a process to collect and analyze pre- and post-provider referral patterns and collect quality information from referral partners (e.g. SNF rehospitalization rates). |
| D. Discharge planners<br><br>Score _____ | …have no process to capture information about post-acute providers' ability to care appropriately for patients with specific diagnosis, treatment, or equipment needs. | …have informal information about a post-acute provider's ability to receive patients with specific needs based on discharge planner knowledge from post-acute provider verbal interactions. Information is passed informally through discharge planning team. | ….collect information about post-acute provider capability, but information is not routinely updated or organized in meaningful categories. | …coordinate with post-acute providers to obtain information about provider capabilities in a standard way *(e.g. all SNFs update and submit INTERACT Capabilities List to hospital)*; consolidate and regularly update information for discharge referral accuracy and efficiency. |

## *Part 7: Care Continuum Coordination, continued*

| Component | Level D *(Score: 1-3)* | Level C *(Score: 4-6)* | Level B *(Score: 7-9)* | Level A *(Score: 10-12)* |
|---|---|---|---|---|
| E. Testing, lab, and referral information that is outstanding at discharge<br><br>Score _____ | …is not routinely conveyed to patients or next setting of care. | …is conveyed via the discharge summary, which may not be transferred to next setting of care in a timely manner.<br>Patient may be unaware there is outstanding information or a need for follow-up procedures. | …is conveyed via the discharge summary and is transferred to next setting of care in a timely manner.<br>Patient discharge instructions include specifics on test results still pending at time of discharge, referrals, and scheduled procedures, but may not specify the reasoning. | …is conveyed via the discharge summary and is transferred to next setting of care in a timely manner.<br>Information is also conveyed verbally to the next setting of care for higher risk situations.<br>Patient discharge instructions and teaching include specifics on test results still pending at time of discharge, referrals, and scheduled procedures, as well as the specific reasoning.<br>Discussion occurs with patient on importance of appointments and tests/labs. |
| F. Community resources<br><br>Score _____ | …are not maintained in any standard referral lists. | …are maintained via referral lists that are outdated, not comprehensive, and vary by team members on various units or departments. | …are maintained via referral lists that are standardized across relevant units and departments, and are occasionally updated.<br>Information for non-medical community resources *(e.g. in-home care, transportation, Meals on Wheels, and other psycho-social support)* may not be a priority. | … are maintained via referral lists that are standardized across relevant units and departments, and are regularly evaluated and updated.<br>Information for non-medical community resources *(e.g. in-home care, transportation, Meals on Wheels, and other psycho-social support) is included.* |