Transition of Care Model for Inpatient & Observation Units
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Abstract
As a committed innovator in healthcare reform, the Suffolk Care Collaborative has developed a Transition of Care Model focused on improving the identification of people at higher risk for readmissions and improving the discharge and post-hospital process to reduce future readmissions. This model was crafted by a true grassroots approach through the collaboration of many stakeholders committed to the improvement of healthcare in our Suffolk County communities. Together we can improve healthcare for our most vulnerable populations; through teamwork we can improve transitions of care to expand care beyond the hospital walls to meet the needs of high-risk patients.

Executive Summary
Baseline specifications for the TOC Program include:

- Procedures reflect implementation of a 30 day transition of care period for high risk inpatient and observation (OBS) patients at participating Suffolk Care Collaborative (SCC) hospitals.
- Care Transition Plan is standardized for the SCC and includes the following minimum requirements: follow up appointments, patient self-education, and medication reconciliation.
- Care Transition Plan to include care record transition protocols with timely updates to primary care provider.
- Early notification of planned discharge is established and maintained in hospital protocols emphasizing early identification/response to high risk patients to avoid adverse events that lead to acute care visits.
- Hospitals allow care managers to visit patients in the hospital and provide care transition services and advisement prior to discharge.
- Implement hospital risk stratification tool and logistics/work-flow to operationalize identification of high-risk patients.
- Partnerships with Home Care and Social Service Agencies & Medicaid Managed Care.
- Establish appropriately sized and staffers observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must be provided.
- Implement methodology or a set of criteria of identifying ED patients who need further care but whose anticipated stay makes the patient a candidate for OBS.
# CMS Conditions of Participation in Discharge Planning

Table demonstration of CMS Conditions of Participation in Discharge Planning guidelines and direct linkage to new NYS DOH DSRIP Program requirements.

<table>
<thead>
<tr>
<th>NYS DOH DSRIP Program Requirement</th>
<th>CMS COP Discharge Planning Guideline</th>
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<tbody>
<tr>
<td>• Policies and procedures reflect implementation of a 30 day transition of care period for high risk inpatient and OBS patients at PPS hospitals</td>
<td>• Hospital must establish follow-up process §482.43</td>
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<tr>
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<td>• Transfer of patients to another healthcare facility must have a specified comprehensive discharge summary §482.43(e)</td>
</tr>
<tr>
<td>• Care Transition Plan is standardized for the SCC and includes the following minimum requirements: follow up appointments, patient self-education, and medication reconciliation</td>
<td>• Identify patients in need of discharge plan and provide written discharge plan for all inpatient as well as observation patients and outpatient surgical patients, identified ER patients, “any other category patient recommended by medical staff” §482.43(b)</td>
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<td></td>
<td>• Patient needs must be identified with standardized comprehensive information §482.43(e)(2)</td>
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<td></td>
<td>• The discharge plan must be included in the patient’s medical record §482.43(c)(9)(i)</td>
</tr>
<tr>
<td>• Care Transition Plan to include care record transition protocols with timely updates to primary care provider</td>
<td>• The hospital must take into consideration the caregiver and community based care availability §482.43(c)(5)</td>
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<td></td>
<td>• Discharge instruction must be given to patient and post-acute care provider and must include home care instructions, prescriptions, med reconciliation, follow up appointments, pending diagnostic tests, pertinent contact information, specified comprehensive medical information §482.43(d)(1&amp;2)</td>
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<tr>
<td></td>
<td>• Hospital must send the discharge summary within 48 hours of patient discharge to the practitioner following up, must have pending test results within 24 hour of their availability §482.43(d)(3)(i&amp;ii)</td>
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<tr>
<td>• Early notification of planned discharge is established and maintained in hospital protocols emphasizing early identification/response to high risk patients to avoid adverse events that lead to acute care visits</td>
<td>Hospital must begin assessing discharge needs within 24 hours of admission, and discharge plan must be completed prior to discharge home or transfer to other facility (including patients hospitalized less than 24 hours) §482.43(c)(2)</td>
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<td>The practitioner responsible for the care must be involved in an ongoing process of discharge planning §482.43(c)(4)</td>
</tr>
<tr>
<td>• Hospitals allow care managers to visit patients in the hospital and provide care transition services and advisement prior to discharge</td>
<td>• Discharge plan with patients goals/needs/ preferences identified §482.43(c)</td>
</tr>
<tr>
<td>• Implement hospital risk stratification tool and logistics/work-flow to operationalize identification of high-risk patients</td>
<td>• Nurse/social work coordinate needs evaluation of the patient §482.43(c)(1)</td>
</tr>
<tr>
<td></td>
<td>• The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is shared and that it is relevant and applicable to the patient’s goals of care and treatment preferences §482.43(c)(8)</td>
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<tr>
<td></td>
<td>• The hospital must assess its discharge planning process on a regular basis of a representative sample of discharge plans, including those patients who were</td>
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Version 2.0
<table>
<thead>
<tr>
<th>PARTNERSHIPS WITH HOME CARE AND SOCIAL SERVICE AGENCIES &amp; MEDICAID MANAGED CARE</th>
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<tbody>
<tr>
<td>• Partnerships with Home Care and Social Service Agencies &amp; Medicaid Managed Care</td>
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<tr>
<td>• The patient and caregiver/support person(s) must be involved in the development of the discharge plan §482.43(c)(6)</td>
</tr>
<tr>
<td>• The discharge plan must identify any financial interests to the SNF or HHA that benefit the hospital and the hospital must respect patient preferences and not limit qualified providers or suppliers available to the patient §482.43(f)(3)</td>
</tr>
<tr>
<td>• The hospital must provide to the patient/patient representative and document in the record a list of practitioners, providers or certified supplies are in the network of the patient’s managed care organization §482.43(f)(1)(ii)</td>
</tr>
<tr>
<td>• The hospital must provide and document in the record the list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available. §482.43(f)(1)</td>
</tr>
<tr>
<td>readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs §482.43(c)(10)</td>
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Transition of Care Coordination Model Overview

Through the Delivery System Reform Incentive Payment (DSRIP) Program, a grant waiver administered by the NYS DOH, dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient focused system to a community-facing system that addresses both medical needs and social determinants of health.

A significant cause of avoidable readmissions is non-adherence with discharge regimens. Non-adherence is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working with the patient to identify the relevant factors and find solutions.

The Suffolk Care Collaborative (SCC) Transition of Care Program’s (TOC) goal is to provide a 30-day supported transition period after a hospitalization to ensure discharge directions and plans are understood and implemented by and for patients at risk of return to acute care, particularly patients with behavioral health disorders. In addition, the program includes establishing appropriately sized observation units (either dedicated beds or scattered beds) in all hospitals in the county to reduce short stay admissions, thereby minimizing Potentially Preventable Readmissions.

The Suffolk Care Collaborative’s Transition of Care Program will be delivered to any Medicaid patient hospitalized at any of the 11 Suffolk County, NY hospitals who meets any or all of the following high-risk criteria as defined by the hospital:

- Readmitted within 30-days of a previous hospitalization;
- History of 3 or more hospitalizations (inpatient or observation) in the past 12 months;
- Any behavioral health comorbidity; and/or
- Unmet social needs, as identified via a social needs screen at or within 24 hours of admission.

These criteria were based on our updated knowledge of the patterns of readmissions among Medicaid patients – specifically the unique features of high risk. The SCC hospitals prioritized high risk criteria that are:

- Data-informed to identify higher than average risk of readmission;
- Able to be reliably identified across 11 hospitals;
- Able to identify high risk patients in real time;
- Able to identify important, current unmet social needs.

SCC hospitals agreed to establish the following structures to support the Transition of Care Program and to manage overall population health and perform as an integrated clinical team:

1. **Written procedure establishing a 30-day transition of care period that will:**
   - State that all patients (observation or inpatient/psych) at high risk of readmission will receive a written transition of care plan provided to them prior to discharge
   - Specify that Medicaid patients will be identified as “high risk” of readmission if: they have been readmitted within 30 days of a prior discharge; have a personal history of 3 or more hospitalizations (inpatient or observation status) in the past 12 months; have any behavioral health comorbidity; and/or have social needs identified by a clinical screen.
• Identify specific community based transition of care providers*, including health homes, as partners in providing transitional care to high risk patients
• State that patients and Transition of Care providers will be notified, ideally, no later than 24 hours prior to discharge of planned discharges
• State that Transition of Care Workers can visit the patient in the hospital pre-discharge to initiate transitional care service planning, recognizing that organizations that provide TOC services should be known to and registered as any other vendor
• State that discharge summaries will be completed within 48 hours of discharge *
• Updating the PCP during the 30-day period; and
• SCC will request that the policy is approved by the hospital’s governing body*

2. Written Transition of Care Plan will include, at minimum, the following elements:
• Patient self-education written at an appropriate health literacy level
• A reconciled medication list*
• Follow up appointment**#

Notes:
* = consistent with new CMS Conditions of Participation for Discharge Planning
# = identified as an operational challenge; area for continuous process improvement
^ = the social needs clinical screen will be developed by each organization

Transition of Care Coordination Services
Each hospital will implement specific workflows and procedures that will accomplish the high-level workflow agreed upon. The TOC Coordination Services workflow includes the following:

STEP 1: Real-Time Identification of Patients at High Risk of Readmission
- Registration system automatically flags Medicaid patients as high risk if any of the following high risk features are present: readmission within 30 days of prior discharge; personal history of 3 or more hospitalizations (inpatient or observation) in the past 12 months; and/or any behavioral health comorbidity as defined by the hospital.
- The real-time flag would identify patients upon admission that they are at high risk of readmission and will be eligible for the Transition of Care service/episode
- The social needs screen will occur at admission or within 24 hours of admission (to inpatient or observation status) for all Medicaid patients; the social needs screen (see Appendix for recommended template) will be conducted by existing hospital staff (role and screening tool may differ by hospital)
- This social needs screen will identify social needs that are not readily identifiable in hospital administrative data, such as social support, transportation, food, affordability of medications or other health-related items, etc.

STEP 2: Early Notification of Patient and Partners of Planned Discharge
- Early notification of planned discharge is established and maintained in hospital protocols emphasizing early identification/response to high risk patients to avoid adverse events that lead to acute care visits
- Patients will be notified of planned discharge, ideally, no later than 24 hours in advance
The Transition of Care provider will be notified of planned discharge, ideally, no later than 24 hours in advance.

Primary care navigation for unassigned patients’ methodology is designed to address managing patients that do not have a PCP. To assure we minimize the gaps that will be identified through the model a member of the care team will look into directing unassigned patients to aligned high performing providers and have care coordinators follow these patients.

Transition of Care provider will be allowed to visit the patient prior to discharge to provide care transition services and advisement prior to discharge, as approved and properly credentialed/on-boarded by the Hospital.

STEP 3: Provision of a Written Transition of Care Plan
- Patients will be provided a written Transition of Care Plan, that includes a minimum, patient self-education written at the appropriate health literacy level, that includes a reconciled medication list) and a follow up appointment.

STEP 4: Timely Completion of the Discharge Summary
- Discharge summaries will be completed within 48 hours of discharge
- Each hospital will specify in the TOC policy and procedures the process by which discharge summaries, once completed, will be transmitted or otherwise made available to the primary care provider. If the discharge summary is not transmitted directly to the PCP, hospitals will describe how PCPs are notified that a discharge summary is available to view, as through a shared EMR, or other electronic portal.

STEP 5: Initiation of a 30-day Transition of Care Period with PCP Updates
- Upon discharge, hospitals will establish a 30 day transitional care period
- The 30-day transition of care period will commence on the day of discharge, and will be measured for 30 calendar days following discharge.
- Transition of Care provider will provide PCP with updates throughout the 30-day period

Communication Methodology for Care Coordination
Care Coordination offers a whole person approach to a patient’s care needs and delivers these needs in an efficient, safe and high quality manner. Elements of Care Coordination can include referrals to skilled home care, durable medical equipment, private hire assistance, home drawn labs, insurance eligibility, transportation assistance, home therapies, elder law, hospice and palliative care, skilled nursing home and assisted living placements, advance directives planning, adult day program and behavioral health. Care Coordination can also include tracking of referrals to primary care physicians and specialists, prescription refills, prior authorizations, lab and radiology referrals and tracking and educational components such as diet, exercise, lifestyle changes, and disease management tasks.

The key to proper coordination of care is communication amongst and between the providers involved in the care team as well as effectively communicating to the patient and/or their families in a way that is culturally and linguistically appropriate. In order to increase the efficacy of the Transition of Care program, measures must be taken to communicate elements of this transition plan to the patient and to the providers involved in that transition. This communication may take place in multiple forms including face to face discussions, telephonic touch points, transmission of transition plans electronically or via fax, and
via other technical communication platforms. All communications must take place in a way that protects the privacy of the health information being discussed.

Through proper communication, collaboration and care coordination, patients may have improved self-efficacy and self-management of their disease process, decreased recovery times, and decreased potential for return to acute care settings.

**Navigation Methodology**

Hospitals may identify potential patients in need of navigation and will coordinate navigating to anyone of the following:

*Community-based Navigation*

Community-based navigation should occur for patients that present with unmet needs. These unmet needs may be identified through the [social needs screening](#). Hospital or Community-based navigators identify, anticipate and help to alleviate any social needs barriers that patients may encounter and should navigate patients until completion of all identified social needs are met. This may include navigation to a PCP or behavioral health needs, navigation to a health home and/or navigation to home care services.

*Health Home Navigation*

The TOC Services will utilize the NYS Health Home Eligibility Criteria to identify and navigate patients for Health Home Services for Chronic Disease. Click [here](#) for the full guidance.

**Step 1:** Identify eligible potential patients or existing Health Home patients

- Health Home Eligibility Criteria:
  - a. Medicaid eligible/active Medicaid; and
  - b. Two (2) or more chronic conditions; or
  - c. One (1) single qualifying condition of either HIV/AIDS or a Serious Mental Illness (SMI)

- Existing Health Home patients may be identified by the [social needs screening](#) (see Appendix)

**Step 2:** Confirm eligibility

**Step 3:** Facilitate referral or hand-off for existing Health Home patients

*Primary Care Practitioner Navigation*

Primary care practitioner navigation for unassigned patients’ methodology is designed to address managing patients that do not have a PCP. To assure we minimize the gaps that will be identified through the model a member of the care team will look into directing unassigned patients to aligned high performing providers and have care coordinators follow these patients.
Workflow Diagrams for TOC Model

Transition of Care Workflow

Version 2.0
Roles & Responsibilities

Hospital Administration
Hospital Administration will be responsible for clinical, financial and operational oversight of the Transition of Care program. Duties to include the development of all TOC policies and procedures, obtain approvals by the hospital’s governing body, as well as monitoring program effectiveness. Hospital Administration shall appoint a Facility Champion who will lead program implementation, as well as work directly with the Suffolk Care Collaborative. Hospital Administration shall designate a multi-disciplinary TOC Program Implementation Team comprised of Hospital staff and may include partnering community-based providers. Hospital Administration will also engage in Community Based Transition of Care partnerships as described here, as well as assuring all reporting responsibilities are fulfilled as described here.

Hospital Information Technology Staff
Hospital Information Technology staff will be committed to effectively building proper documentation requirements for the Hospitals’ electronic medical record, including building and generating on-going reports to support Hospital Administration.

Hospital-based providers
Hospital-based providers will be charged with completing the discharge summary within 48 hours of discharge. This may include communicating directly with community-based primary care providers (PCP).

Hospital-based discharge planner/case manager
Hospital-based discharge planner/case managers will be responsible for the following: the social needs screen on admission, writing and preparing the TOC Plan with the required elements, notifying the patient, ideally, within 24 hours of planned discharge, notifying TOC Provider, ideally, within 24 hours of planned discharge and identifying and navigating health home eligible patients to health homes or other navigation services.

Transition of Care Provider
The Transition of Care (TOC) Provider is responsible for having proper receiving mechanism in place to accept the Hospital’s notification that client is being discharged timely, will visit the client in hospital prior to discharge, as able, collaborate with the primary care physician and monitor the patient during the TOC. In addition, the TOC provider will act on any unmet social need that is identified based on the Hospital-based discharge planner/case manager, to include communicating with the Hospital-based discharge planner/case manager to assure appropriate care coordination and navigation takes place. The TOC provider role can be fulfilled by, but not limited to, Care Management Organization, Hospital, Hospital designated staff, Home Care Service, Health Home, Community Agency, Social Service, and Medicaid Managed Care Organizations.

Community-based PCP
Community-based primary care providers (PCP), must assure they have a proper mechanism in place to accept the Hospital’s communications timely, receive, review, and act on the TOC plan, and receive updates throughout 30 day care plan from TOC Provider.

Community-based Behavioral Health Provider
Community-based behavioral health providers (BH), must assure they have a proper mechanism in place to accept the Hospital’s communications timely, receive, review, and act on the TOC plan, and receive updates throughout 30 day care plan from TOC Provider.
Community-based Social Service Providers
Community-based social service providers, must assure they have a proper mechanism in place to accept the Hospital’s communications timely, receive, review, and act on the TOC plan, and receive updates throughout 30 day care plan from TOC Providers.

Community-based Home Care Providers
Community-based home care providers or other appropriate community agencies, must assure they have a proper mechanism in place to accept the Hospital’s communications timely, receive, review, and act on the TOC plan, and receive updates throughout 30 day care plan from TOC Provider.

Health Homes
A Health Home must be able to work with health and community agencies to support Medicaid members with serious and chronic health issues obtain additional support services to stay health and safe within their community. The Health Home must also be able to provide a care manager to a patient for the purposes of care coordination.

Medicaid Managed Care Organizations
Medicaid managed Care Organizations are responsible for establishing care coordination services with all participating SCC-partners. The SCC will establish strong working relationships with regional Medicaid Managed Care Organizations including MCO payment strategies for the TOC services. The SCC will review the TOC model with MCOs, identify SCC high risk criteria for TOC, inquire and codify MCOs’ high risk criteria for care management, TOC, or other outreach services. The PPS will identify opportunities to develop efficient and effective communication processes for hospitals to facilitate collaboration regarding shared patients and MCO members’ TOC needs to avoid duplication of effort and to avoid gaps in care, including timeliness of post-hospital contact.

Training Methodology
Each hospital will establish its own process for training key stakeholders, managers and staff in the DSRIP TOC model. The SCC will support hospitals’ efforts by providing general and role-specific minimum guidance and training materials that hospitals may use or customize to meet their needs.

Please find the required training modules located in Section 3 of the SCC TOC/OBS Toolkit.

Community Based TOC Partnerships
Partnerships with Home Care & Social Service Agencies
The Hospital will establish strong working relationships and partnerships with home care and social service providers (such as medically tailored home food services) to ensure appropriate social service and home care are provided in discharge planning and transitional care management. The Hospital will review the TOC model with TOC Providers, and ensure they are knowledgeable of community based resources for transitional care management, navigation or other outreach services. The SCC will identify opportunities to develop efficient and effective resource directories, communication processes for Hospital to facilitate collaboration regarding home care and social service resources; through future project stakeholder meetings.
Partnerships with Medicaid Managed Care Plans & Health Homes

The PPS will establish strong working relationships with regional Medicaid Managed Care Organizations and Health Homes on behalf of SCC partner hospitals to ensure proper discharge processes are followed. The SCC will review the TOC model with MCOs and Health Homes, identify high risk criteria for TOC, inquire and codify MCOs’ and Health Homes for high risk criteria for care management, TOC, or other outreach services. The SCC will identify opportunities to develop efficient and effective communication processes for SCC partnered hospitals to facilitate collaboration regarding shared patients and Health Home and MCO members’ TOC needs to avoid duplication of effort and to avoid gaps in care, including timeliness of post-hospital contact.

**Observation Unit (OBS)**

**Purpose**

With the increased overcrowding of emergency rooms and the associated costs, hospitals have begun to create observation units. The purpose of observation is to determine the need for further treatment or for inpatient admission. Observation units are designed for patients who may not present quickly as needing to be admitted for inpatient services and who are also unstable for discharge. Increased research into the use of observation units has shown that outcomes include shorter lengths-of-stay, lower rates of inpatient admissions, decreased rate of hospital-acquired infections, greater patient satisfaction, better clinical outcomes, and improvements in the use of hospital resources. Observation units also allow emergency departments to efficiently utilize appropriate staff without reducing the standard of care for critical patients that may present to the emergency room.

**Workflow diagram Observation Status**
Methodology to define Observation level of care
The Hospitals will use the State and Federal guidelines to define observation level of care. Patients that present to the Emergency Department requiring more than 24 hours of care as deemed by a physician are candidates to be placed into the observation unit. The decision by a physician to place a patient into observation should be based on the patient’s medical history and current medical needs, the types of facilities available at the inpatient and outpatient level and relative appropriateness of treatment in each setting.

Establishing Appropriately Sized OBS Unit
Hospitals may operationalize a unit-based or scattered-bed approach to their observation program. Hospital will establish appropriately sized and staffed observation programs. Regardless of the approach, hospitals will ensure care coordination is provided as part of the TOC model. Hospitals will determine the clinical and financial model to support the need for the observation program as part of the DSRIP requirements, as well as benchmarking progress towards meeting clinical and financial goals annually.

Transition of Care Coordination Services (Click here)
Primary Care Navigation for Unassigned Patients (Click here)

Program Reporting Procedure to the SCC
This section will describe how Hospitals will demonstrate completion of DSRIP project requirements to the SCC.

One-time Reporting Requirements
The TOC Facility Champion will designate a user in the SCC Project Management Office’s web-based project management software which will host a TOC/OBS Hospital-Implementation plan. This implementation plan is a consolidated set of tasks used to monitor progress towards the implementation of the TOC/OBS Program. In addition to completing the implementation plan, the user will submit documents to the SCC to demonstrate the TOC/OBS program was implemented, this may include, training sign-in sheets.

Quarterly Reporting Requirements
Quarterly reporting requirements for the Transition of Care Program (DSRIP Project 2biv) and Observation Program (DSRIP Project 2bix) are the following:

1. Transition of Care Program Patient Engagement: As per the definition of actively engaged, patient engagement refers to the number of participating patients who receive discharge instructions that include patient self-education, medication reconciliation, and follow-up appointments, prior to discharge. Duplicate counts of patients are allowed within 1 DSRIP measurement year, if the patient has multiple encounters, each encounter is counted. For example, if a patient receives TOC care plans on 5 discharges in a year, we count it 5 times in that DSRIP year.

2. Observation Program Patient Engagement: As per the definition of actively engaged, patient engagement refers to the number of participating patients who are utilizing the OBS services that meet project requirements. Duplicate counts of patients are not allowed within 1 DSRIP measurement year. Counts are not additive across DSRIP years.
All Suffolk County Hospitals participating in the program will follow the quarterly reporting schedule and specifications as outlined on the SCC Data Request webpage.

**How to measure success of 30-day TOC Period High Risk**

**Recommended Data Analytics**

PPS Hospitals will be encouraged to establish a minimally consistent data analysis and reporting plan across all PPS hospitals. A minimally consistent data analysis approach will facilitate required reporting at the PPS level. In addition, it will greatly facilitate operational improvement. This parsimonious set of measures will be a foundation for individual hospitals and TOC programs to build upon. It is not intended to represent all informative measures, but rather a minimal set of measures that would serve to drive operational improvement.

We recommend that each hospital track and report the following on a monthly basis:

**At the hospital level:**
- Total Medicaid discharges (total encounters)
- Total number of Medicaid patients discharged (total unique MRNs)
- Total number of discharges followed by readmission <30 days for any reason

**For the target population (High Utilizer, Readmission, Behavior Health or positive on social needs screen*):**
- Total Medicaid discharges (total encounters)
- Total number of Medicaid patients discharged (total unique MRNs)
- Total number of discharges followed by readmission <30 days for any reason
- Total number (and %) of target population patients offered TOC services
- Total number (and %) of target population patients who agreed to TOC services
- Total number (and %) of target population patients who had TOC visit prior to discharge
- Total number (and %) of target population patients who completed 30-day TOC services

Using these measures, the following analysis will be conducted – at the hospital, system and PPS levels:
- What % of all Medicaid patients were found to meet high risk criteria?
- What % of patients who met high risk criteria were offered TOC services?
- What % of patients who were offered TOC services enrolled?
- What % of patients who enrolled in TOC services had a pre-discharge TOC encounter?
- What % of patients who enrolled in TOC services completed the 30-day episode?
- What is the raw, unadjusted all cause (hospital-specific) 30 day readmission rate for the total Medicaid population?
- What is the raw, unadjusted all cause (hospital-specific) 30-day readmission rate for the discharges that met high risk criteria?
- What is the raw, unadjusted all cause (hospital-specific) 30-day readmission rate for the patients who enrolled and completed the 30-day TOC episode?
- Consistently measured monthly run charts: total discharges, total readmissions, total number of high risk patients identified, total number of high risk patients served
Post Discharge Interventions

Suffolk Care Collaborative Post-Discharge Protocol

The Suffolk Care Collaborative Post-Discharge Protocol (2biv.2bix.03) speaks to the role of the Transition of Care (TOC) Provider during the 30-day Patient Care period. The Suffolk Care Collaborative Post-Discharge Protocol can be found in Section 2 of the SCC TOC/OBS Toolkit.

Post-Discharge Workflow

**Transition of Care Post-Discharge Workflow**

<table>
<thead>
<tr>
<th>Suffolk Care Collaborative</th>
<th>December 2016</th>
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<tbody>
<tr>
<td>TOC Provider begins to coordinate 30-day services for patient upon discharge</td>
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<tr>
<td>Navigation to social determinants of health, such as food, including medically tailored food, housing, including supportive housing &amp; transportation</td>
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**TOC Providers include:**
- Health Homes
- Managed Medicaid Care Organizations
- Care Management Organizations

**30-day Patient Care**

- Patient Education on diagnosis, reason for hospitalizations & discharge instructions
- Communication check points with patient, including PCP follow-up appointment
- Updates to PCP during 30-day follow
- Provide medical and behavioral support
- End of Life Planning, including MOLST, as appropriate

**Social Determinants of Health**

- Initiation of 30-day Services
- Suffolk Care Collaborative
Post-Discharge Interventions & Tools

Disclaimer: The Suffolk Care Collaborative Post-Discharge Interventions & Tools section of the Transition of Care Model is a recommended section. We have included this section to provide our partners with post-discharge tools. At no point in this section, is any of the language or tools provided required for use in your organization. The SCC has sourced many of the tools from the Washington State Hospital Association, *Reducing Readmissions: Care Transitions Toolkit*, 2014. This toolkit can be found in the References section.

Follow up Interventions Based on Patients’ Readmission Risk Factors

Patients who are discharged from hospitals with early follow-up appointment dates have a lower risk of 30-day readmission. There is a relationship between early physician follow-up and 30-day readmissions. Most readmissions occur in the first few days post-discharge. The grid below speaks to the recommended process that should occur for patients with an established PCP.

*Triage Grid: Follow up & Interventions Based on Patients’ Readmission Risk*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Appointment Needed within (timeframe)</th>
<th>Handoff</th>
<th>Discharge Summary</th>
<th>Interventions Prior to Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted 2 or more times in the past year</td>
<td>48 hours</td>
<td>Doctor to Doctor</td>
<td>Phone AND Fax</td>
<td>Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or Home Health care is the best option for the patient.</td>
</tr>
<tr>
<td>Unable to Teach Back</td>
<td>5 – 7 days</td>
<td>Hospital to PCP team</td>
<td>EHR or Fax</td>
<td>If a Home Health care visit is scheduled in the first 48 hours. An office visit might be slightly later but must also be scheduled within 5 days.</td>
</tr>
<tr>
<td>Low likelihood to follow treatment plan</td>
<td></td>
<td></td>
<td></td>
<td>Initiate supportive care management programs as indicated (if not provided in primary or in outpatient specialty clinic (e.g. heart failure, stroke clinics))</td>
</tr>
<tr>
<td>High likelihood patient readmitted within 30 days</td>
<td>5 - 7 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted once in the past year</td>
<td></td>
<td></td>
<td></td>
<td>Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit within 5 – 7 days</td>
</tr>
<tr>
<td>Moderate likelihood to follow treatment plan</td>
<td></td>
<td></td>
<td></td>
<td>Initiate in-home services (health home, palliative/hospice care or home care) or transitional care services as needed</td>
</tr>
<tr>
<td>Moderate likelihood patient readmitted within 30 days</td>
<td></td>
<td></td>
<td></td>
<td>Provide 24/7 phone number for advice about questions and concerns</td>
</tr>
<tr>
<td>No other admission in the past year</td>
<td></td>
<td></td>
<td></td>
<td>Initiate a referral to social services and community resources as needed</td>
</tr>
<tr>
<td>Able to Teach Back</td>
<td></td>
<td></td>
<td></td>
<td>Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit</td>
</tr>
<tr>
<td>Low likelihood patient readmitted within 30 days</td>
<td></td>
<td></td>
<td></td>
<td>Provide 24/7 phone number for advice about questions and concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Initiate a referral to social services and community resources as needed</td>
</tr>
</tbody>
</table>
### TRANSITION OF CARE MODEL FOR INPATIENT & OBSERVATION UNITS

- Provide a 24/7 phone number for advice about questions and concerns
- Initiate a referral to social services and community resources as needed

**Source:** The Triage Grid above was adapted by the Washington State Hospital Association Partnership for Patients Transition of Care Toolkit and the Rutherford, P. et. al. How to Guide: Improving Transitions for the Hospital to Community Settings to Reduce Avoidable Re-Hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2012. [www.ihi.org](http://www.ihi.org).

Version 2.0
## The 8 P’s: Assessing Your Patients Risk for Adverse Events after Discharge

<table>
<thead>
<tr>
<th>Risk Assessment: 8P Screening Tool (Check all that apply)</th>
<th>Risk Specific Intervention</th>
<th>Signature of Individual Responsible for Insuring Intervention Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem medications</strong>&lt;br&gt; (anticoagulants, insulin, oral hypoglycemic agents, aspirin &amp; clopidogrel dual therapy, digoxin, narcotics)</td>
<td>□ Medication specific education using Teach Back provided to patient and caregiver&lt;br&gt; □ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)&lt;br&gt; □ Specific strategies for managing adverse drug events reviewed with patient/caregiver&lt;br&gt; □ Follow-up phone call at 72 hours assess adherence and complications&lt;br&gt; □ Follow-up appointment with aftercare medical provider within 7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological</strong>&lt;br&gt; (depression screen positive or h/o depression diagnosis)</td>
<td>□ Assessment of need for psychiatric aftercare if not in place&lt;br&gt; □ Communication with aftercare providers, highlighting this use if new&lt;br&gt; □ Involvement/awareness of support network insured&lt;br&gt; □ Follow-up appointment with aftercare medical provider within 7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Principal diagnosis</strong>&lt;br&gt; (cancer, stroke, DM, COPD, heart failure)</td>
<td>□ Review of national discharge guidelines, where available&lt;br&gt; □ Disease specific education suing Teach Back with patient/caregiver&lt;br&gt; □ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms&lt;br&gt; □ Discuss goals of care and chronic illness model discussed with patient/caregiver&lt;br&gt; □ Follow-up appointment with aftercare medical provider within 7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Polypharmacy</strong>&lt;br&gt; (≥5 more routine meds)</td>
<td>□ Elimination of unnecessary medications&lt;br&gt; □ Simplification of medication scheduling to improve adherence&lt;br&gt; □ Follow-up phone call at 72 hours to assess adherence and complications&lt;br&gt; □ Follow-up appointment with aftercare medical provider within 7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Poor health literacy</strong>&lt;br&gt; (inability to do Teach Back)</td>
<td>□ Committed caregiver involved in planning/administration of all general and risk specific interventions&lt;br&gt; □ Aftercare plan education using Teach Back provided to patient and caregiver&lt;br&gt; □ Link to community resources for additional patient/caregiver support</td>
<td></td>
</tr>
</tbody>
</table>
## TRANSITION OF CARE MODEL FOR INPATIENT & OBSERVATION UNITS

<table>
<thead>
<tr>
<th>Category</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow-up phone call at 72 hours</strong></td>
<td>Assess adherence and complications</td>
</tr>
<tr>
<td><strong>Follow-up appointment</strong></td>
<td>With aftercare medical provider within 7 days</td>
</tr>
</tbody>
</table>

### Patient support

( absence of caregiver to assist with discharge and home care)

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up phone call at 72 hours to assess adherence and complications</td>
</tr>
<tr>
<td>Follow-up appointment with aftercare medical provider within 7 days</td>
</tr>
<tr>
<td>Involvement of how care providers of services with clear communications of discharge plan to these providers</td>
</tr>
</tbody>
</table>

### Prior hospitalization

( non-elective; in last 6 months)

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review reasons for re-hospitalization in context of prior hospitalization</td>
</tr>
<tr>
<td>Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
</tr>
<tr>
<td>Follow-up appointment with aftercare medical provider within 7 days</td>
</tr>
</tbody>
</table>

### Palliative care

Yes to either: (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?)

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess need for palliative care services</td>
</tr>
<tr>
<td>Identify goals of care and therapeutic options</td>
</tr>
<tr>
<td>Communicate prognosis with patient/family/caregiver</td>
</tr>
<tr>
<td>Assess and address bothersome symptoms</td>
</tr>
<tr>
<td>Identify services or benefits available to patients based on advanced disease status</td>
</tr>
<tr>
<td>Discuss with patient/family/caregiver role of palliative care services and benefits and services available</td>
</tr>
<tr>
<td>Follow-up appointment with aftercare medical provider within 7 days</td>
</tr>
</tbody>
</table>

**Source:** The 8 P’s Grid above was adapted by the Washington State Hospital Association Partnership for Patients Transition of Care Toolkit and the Rutherford, P. et. al. How to Guide: Improving Transitions for the Hospital to Community Settings to Reduce Avoidable Re-Hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2012. [www.ihi.org](http://www.ihi.org).
Scheduling the Follow-Up Appointment

**Note:** The processes below were adapted by the Washington State Hospital Association Partnership for Patients Transition of Care Toolkit and the Rutherford, P. et. al. How to Guide: Improving Transitions for the Hospital to Community Settings to Reduce Avoidable Re-Hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2012. The Suffolk Care Collaborative is providing these materials as Recommended Post-Discharge Tools and they can be found at [www.IHI.org](http://www.IHI.org)

**Process for Patients without an Established PCP:**
Make attempts for the patient to get registered with a PCP for continuity of care if they do not currently have an established PCP. In addition, develop processes for those patients to receive necessary follow-up appointments within the recommended time frame.

- If the patient is insured with a managed care plan, contact the plan to provide the patient with assistance getting the necessary follow-up appointments.
- Hospital will identify a network of providers to accept uninsured patients, which may include primary care clinic, affiliated or community-based providers.
  - If the patient is uninsured and if the hospital has a primary care clinic or affiliated primary care practice, work with the clinic to identify the number of appointments that should be reserved for post-hospital visits. Make arrangements between clinics and hospitals if a slot has not been filled for a post-discharge visit by certain time/day before the appointment, it is released for general appointment scheduling by the clinic. This may involve hospital senior leadership in the discussions to set overall access needs.
  - If the hospital does not have a primary care clinic or an affiliated primary care practice or cannot meet overall access needs, identify other clinics in the community that provide primary care services. Discuss the need for primary care follow-up appointments for patients that are a high risk for readmissions and determine access needs. Collaborate with each practice administrator to plan access needs.

**Process for Patients with an Established PCP:**

- Schedule discharge appointments based on the triage grid
- For patients who are at a high or moderate risk for readmission, hospital staff schedules a follow-up appointment with the PCP prior to discharge
- Work with the patient and their caregiver to determine and address existing barriers in attending their follow-up appointment such as transportation or availability of the caregiver to accompany them to the appointment
- Ensure that the patient and their caregiver understand the purpose and importance of the follow-up appointment. Encourage the patient or their caregiver to reschedule the appointment if they are unable to make the scheduled time. In the discharge instructions, document the follow up appoint date, time and provider and reason for the appointment
- If in-home service referrals are made, include the date and time of the primary care follow-up appointment on the referral so the agency can support getting the patient to the appointment and can notify the physician of any significant findings prior to the appointment
- The [Primary Care Provider Notification Tool](http://www.IHI.org) can be used to increase communication between the acute care facility and the primary care provider but is not meant to replace the transmission of the acute care discharge summary to the Primary Care Provider within 48 hours of discharge.
Primary Care Provider Notification Tool

Patient Information

Patient Name: _____________________________ Date of Birth: ___/___/___

Gender: □ Male □ Female

Admission Information:

Visit/Admission Date: ___/___/___

Admit reason/ Anticipated diagnosis/ Admit diagnosis: _______________________________________

Attending Name & Number: ______________________________ Location: ______________________

Additional Contact Name & Number: ______________________________________________________

*If you are not this patient’s Primary Care Provider or you believe you have received this notice in error, please call/fax to ___________*


Effective Communication Methods


Teach Back

Teach Back is one of the most effective methods for educating patients. Teach Back involves asking the patient or family and caregiver to recall and restate in their own words what they thought they heard during education or other instructions. Refer to the Harrison Medical Center’s tool.

Teach Back is used to assess patient and family understanding of information and education to improve their ability to perform self-care, take medications, recognize warning signs/symptoms, access help, and more. It includes the following:

- Explain needed information: Include the patient and family caregivers
- Check for Understanding: Ask in a supportive way for them in their own words what was understood. For example, “I want to make sure I explained everything to you clearly. Could you explain to me in your own words...?”
- Check for understanding by the patient after each portion of the information. For example, after telling the patient how to take their water pill and again after explaining the reasons to call the doctor.
- Patients and caregivers should not feel Teach Back is a test. The emphasis is on how well you explain the concepts, placing the responsibility on the teacher not the learner.
• If a gap in understanding is identified, offer additional teaching or explanation followed by a second request for the patient to explain in their own words. Emphasize what they must do when they get home.
• Use multiple opportunities while the patient is in the hospital for review of important information to increase patient and family caregiver recall and confidence.
• If the patient or family caregiver cannot Teach Back, inform the care providers in the next care setting and adjust the transition plan accordingly.
• Use a standardized template to prompt nurses and other clinicians to document the patient’s understanding of what was taught, for example a formatted Teach Back note in the patient’s chart.
• Utilize a checklist to ensure that all needed follow-up conversations and services occur

Harrison Medical Center Teach Back Education Tool

Motivational Interviewing

Motivational interviewing is a respectful stance with a focus on building rapport in the initial stages of the counseling relationship. A central concept is the identification, examination, and resolution of ambivalence about changing behavior.

Motivational Interviewing includes three essential elements:
1. A particular kind of conversation about change (counseling, therapy, consultation, method of communication)
2. Collaboration (person-centered, partnership, honors autonomy, not expert-recipient)
3. Evocation (seeks to call forth the person’s own motivation and commitment)

Clinical Applications within Motivational Interviewing

- **Do: Express empathy**
  - Find some success to acknowledge, give good news, provide information if needed, reflect your understanding of what they are saying, develop discrepancy and summarize.

- **Do: “Roll with Resistance”**
  - Sample responses: “It sounds like right now isn’t the right time to do this given the other pressures in your life.” “If you didn’t have this going on right now, how would you feel about doing this? Looking ahead 6 months, where do you see yourself in terms of your health?” “You seem to understand the changes that would help improve your diabetes control, but you are not ready to commit to more changes today. We can revisit this area again in the future.”

- **Don’t:**
  - Argue, lecture without eliciting patient views on the change area, use data as “proof” of problem

Basic Communication Technique

- **OARS**
  - Open Ended Questions can be more efficient because they elicit more reliable and complete information and do not have to lead to lengthy discussions.
    - These cannot be answered with a Yes or No or short one-word responses
    - Are not rhetorical
    - Probe widely for information
    - Help uncover the individual’s priorities and values
    - Avoid socially desirable responses
    - Draw people out
  - Affirmations help your patient feel more comfortable, forthcoming and open to feedback. Affirmations can be brief but powerful in building a therapeutic alliance.
    - Affirm a person’s struggles, achievements, values and feeling
    - Emphasize a strength
    - Notice and appreciate a positive action, even a small one
  - Reflections repeat or rephrase what the patient has said
    - Communicate that you have listened
    - Serve as check that you correctly understood what the patient said
    - Can be an effective, non-confrontational way to reduce resistance
    - Can also expand on the meaning of what the patient has said
  - Summarization brings closure and consensus to what has been discussed and sets the stage for next steps
Checklist for Post-Hospital Follow-up Visits

Plan of Care and Medication Reconciliation

1. Ask the patient to explain:
   - Goals for the visit
   - What factors contributed to hospital admission or ED visit
   - Medication patient is taking and schedule

2. Perform medication reconciliation with attentions to the pre-hospital regimen. Define the need to:
   - Adjust medications of dosages
   - Follow up on test results
   - Monitor or test
   - Discuss end-of-life planning
   - Discuss patient preferences for specific future treatment and advanced care planning. The Medical Orders for Life Sustaining Treatment (MOLST) form may be used as a tool

3. Instruct patient in self-management; ask the patient to repeat back

4. Provide instructions for seeking emergency and non-emergency after-hours care

5. At the End of the Visit:
   - Print reconciled dates, medication list and provide a copy to the patient, family caregiver, home health, palliative/hospice or home care nurse and case manager, if appropriate.

Communicate any revisions of the care plan to family caregivers, home health, palliative/hospice or home care nurse and case manager, if appropriate.

**Warm Handoff**

Poorly executed care transitions negatively affect patients’ health, wellbeing, and family resources as well as unnecessarily increase health care system costs. Continuity in patients’ medical care is especially critical following a hospital discharge. This section focuses on discharges from hospital to home with primary care provider follow-up and discharges from hospital to a skilled nursing facility (SNF).

- Perform warm handoff from clinical to clinical when a high-risk patient is transitioned home or to a sub-acute care setting. Warm handoff enables providers to discuss the treatment plan in detail, areas of concern that need attention in the post-discharge period, alert the receiving facility/provider to be prepared to accept the patient and that they are capable of providing the recommend care for the patient.
- Complete a discharge summary that includes medication reconciliation, patient education and a follow-up appointment. Refer to the Scheduling Follow-up Appointment tool.
- Establish reliable and sustainable processes to ensure that outpatient providers receive a document containing sufficient information to allow them to manage the patient on the day of the patient’s follow-up appointment. Hospitals should create expectations that physicians and systems provide a complete discharge summary to the primary care provider, skilled nursing facility, or other follow-up appointment, as per SCC’s TOC Model.
- Provide the patient or caregiver a copy of the discharge instructions that includes the plan of care, medication reconciliation, patient education and follow up appointment. Additional information that could be included but is not specified in the SCC TOC Model include information on specific signs and symptoms that warrant follow up with the clinician, when to seek emergency care, how to contact the primary care physician, and a 24/7 phone number for advice about questions and concerns.

**Scheduling Follow-up Appointments**

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name: ___________________</td>
</tr>
<tr>
<td>Gender: □ Male □ Female</td>
</tr>
<tr>
<td>Discharged On: [Date] with [Diagnosis]</td>
</tr>
<tr>
<td>Appointments made: □ Yes □ No</td>
</tr>
<tr>
<td>If no, why not? ___________________</td>
</tr>
<tr>
<td>Has transportation? □ Yes □ No</td>
</tr>
<tr>
<td>If no, document intervention: ___________________</td>
</tr>
<tr>
<td>Any barriers to completing appointments? □ Yes □ No</td>
</tr>
<tr>
<td>If yes, what are barriers? ___________________</td>
</tr>
<tr>
<td>Interventions to address those barriers ___________________</td>
</tr>
<tr>
<td>Follow up with [Provider] on [Date &amp; Time]. Transportation plan discussed.</td>
</tr>
</tbody>
</table>

**Source:** The Scheduling Follow-up Appointments Tool above was adapted by the Washington State Hospital Association Partnership for Patients Transition of Care Toolkit and the Rutherford, P. et. al. How to Guide: Improving Transitions for the Hospital to Community Settings to Reduce Avoidable Re-Hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2012. [www.IHI.org](http://www.IHI.org).
Advanced Care Planning
Patients who have advanced care planning involvement spend 10 fewer days in the hospital during their last two years and have fewer readmissions than those without as many elect to spend the time at home with family. When patients are involved with and educated on end-of-life care outside of the hospital, hospitalization rates in the subsequent 30 to 180 days are decreased by 40 percent to 50 percent.

Researchers sponsored by AHRQ have suggested a five-part process that physicians can use to structure discussions on end-of-life care:

- Initiate a guided discussion
- Introduce the subject of advanced care planning and offer information
- Prepare and complete advanced care planning documents
- Review the patient’s preferences on a regular basis and update documentation
- Apply the patient’s desires to actual circumstances

The most proactive approach is through standardization of three on-going conversations:

1. Initiating Advanced Directive discussions while people are still healthy – encouraging conversations with family members and writing those wishes down
2. Discussing Advanced Directives after terminal illness diagnosis and updating Advanced Directives based on current diagnosis
3. Initiating MOLST and updating Advanced Directives as part of ongoing care for chronic conditions and aging
4. Ensuring that MOLST moves with the patient between setting; helping patients understand the limitations of MOLST

Post-Discharge Quality Improvement

Feedback to Hospital/ED for Quality Improvement

Primary Care Providers and other pre- and post-acute care providers are encouraged to provide feedback to the hospitals regarding issues within the transition. Refer to the Primary Care Provider Feedback to Hospital tool.

- Pre- and post-acute care providers, patients and their families should provide feedback to the hospitals using a form such the Primary Care Provider Feedback tool, at a community forum, using patient and family resource phone number or provider feedback phone number
- The community comprised of leadership from the hospitals, pre- and post-acute care providers, patients and families should review the feedback together in their forum and establish process to improve transitions.
Primary Care Provider Feedback to Hospital

| Date: __________ |
| Primary Care Provider: _________________________________ |
| Contact Information: ___________________________________________________________________ |
| Patient Name: ___________________________________ |
| Admission Date: __________ |
| Discharge Date: __________ |
| Patient had a post-discharge appointment on: ______________ |
| Did patient keep the scheduled appointment? □ Yes □ No |
| If no, describe: |
| □ Patient was unaware of the appointment date and time |
| □ Patient was unclear of the reason why they need the follow-up appointment |
| □ Patient has no transportation to go to the appointment |
| □ Appointment date and time is inconvenient for the caregiver to accompany the patient |
| Did the patient remember the two most important elements for self-care? □ Yes □ No |
| If no, describe: ___________________________________________________________________ |
| Suggestions that would be helpful for the hospital to know when caring for future patients: ____________________________________________ |

Please contact primary care at [Telephone Number] if you have questions.

References


Centers for Medicare and Medicaid Services: Conditions of Participation Discharge Planning Guidelines, Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 482, 484, 485; *Medicare and Medicaid Programs: Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule* (November 3, 2015).


