



TRANSITIONS  
OF CARE  
PLANNING  
GUIDE

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# INTRODUCTION

*Transitions of Care* encompasses a broad range of services and environments designed to promote the safe and timely passage of clients between levels of care and across health care settings. Strong transitions of care are crucial for those with serious and persistent mental illness, substance use disorders and other chronic health conditions. These clients typically receive care from many providers and move frequently within health care settings. For the purposes of this guide, “transitions of care” between settings includes inpatient discharges to community based care, including primary care, community-based behavioral health services, outpatient specialist referrals and follow-up visits, as well as ER diversion processes.

The Transitions of Care Planning Guide (“Guide”) is designed to support practices in strengthening their organizational capacity to safely and effectively transition clients between care settings. Practices can use the Guide to create and execute their own strategy to collaborate with other providers to identify the barriers to smooth transitions and identify, implement, and evaluate collective solutions. The overall aim is to increase the rates of follow-up care post-discharge, decrease avoidable readmissions, and improve the quality and experience of care for clients, families and provider organizations alike.

## WHY FOCUS ON TRANSITIONS OF CARE?

Ineffective transitions between levels of care results in poor patient outcomes and avoidable re-hospitalization rates. Approximately 16.3 percent of Medicaid clients return to the hospital within 30 days of discharge.<sup>1</sup> Effective transitions of care are material to behavioral health providers as hospital stays for people with mood disorders or schizophrenia are more likely to be followed by a readmission following discharge compared with stays for non-behavioral health related admissions.<sup>2</sup> In fact, a combination of mental illness and substance abuse is associated with a 4 to 5-fold increase in overall hospital admission rates for chronically ill populations.<sup>3</sup> Improved care transitions can decrease the probability of a patient’s decline in health status, subsequently reducing avoidable hospital readmissions.

## INTENDED AUDIENCE:

The Guide can be used by behavioral health providers, primary care providers, hospitals, emergency rooms (ERs), community based organizations and other entities that share accountability for patient/client outcomes. Note that each provider may use this Guide a little differently, based on the setting and the organization’s role in the continuum of care. Working together with other community partners, any provider can use the Guide to develop and implement strategies, integrated workflows, communication processes, and quality improvement (QI) plans all aimed at improving transitions of care.

## HOW TO USE THIS GUIDE

This guide was originally designed for participants in the Care Transitions Network (hyperlink to CTN webpage), to support the creation of a comprehensive plan for achieving effective transitions of care. The guide supports achievement of core competencies and best practices outlined in CMS' Practice Assessment Tool (link) related to:

-  Clients and Families Collaborate in Goal Setting, Decision-Making and Self-Management
-  Formal Approach to Obtaining Patient and Family Feedback
-  Referrals to Appropriate Community Resources
-  Work with Primary Care Practices in the Medical Neighborhood
-  Identifying Primary Care Provider or Care Team and Team Communication
-  Use of Evidence-based Protocols or Care Maps
-  Use of Technology to Improve Access and Communication
-  Formal Approach to Understanding Work Processes

In addition, the Guide can also be used by any organization seeking to create and execute a strategy to improve transitions of care. It has been organized into ten sections, each of which addresses processes in transitions of care, and for each of which principal elements of the processes are listed. Note that the Guide is adapted from the model used by the [National Transitions of Care Coalition \(NTOCC\)](#) and [Washington State Hospital Association's Reducing Readmissions: Care Transitions Toolkit](#).

This Guide serves as a starting point and a template for your organization to begin its own process of developing and implementing safe and efficient transitions of care. The downloadable [Key Elements Worksheet](#),<sup>4</sup> comprised of the tables found below, can and should be customized by your team to ensure your goals and objectives are reflected in your plan. References and links to best practices are also included in the last section should you wish to consult more in-depth information.

## GETTING STARTED

To begin, gather some preliminary information about the current state of your transitions of care processes and relevant information from the field. Specifically:

1. List members of your medical neighborhood. Who are the other providers in your community that care for your population? What hospitals/ERs, primary care, specialty care, and CBO organizations share patients/clients most frequently? Identify contacts for these and prepare to enlist them your transitions of care work.
2. Investigate your organization's current performance on transitions of care. Do you have a way of tracking how patients move along the continuum of care? For example, do you know what percentage of clients are seen by their outpatient providers within 7 and 30 days of an inpatient discharge? Do you know whether people consistently get a follow-up phone call?
3. Identify your existing CARE PATHWAYS, and plan to add to and modify them to include community partners. Do you currently have a way of identifying clients most at risk of admission or readmission? Do you have special protocols or processes for managing their care?
4. Select your Transitions of Care project team. Name individuals in your organization who will be charged with leading your efforts to improve transitions of care, as well as their roles and responsibilities in the project. Remember that effective implementation will call upon administrative and clinical staff alike to develop new procedures and act as champions for the entire staff.
5. Consult the literature to acquaint your team with specific approaches that have demonstrated impact on admissions among behavioral health patients and can inform your work going forward. One example is New York State Office of Mental Health's [Reducing Behavioral Health Readmissions: Strategies and Lessons Learned](#).



# PART A. INITIAL CONTACT

## 1. Intake And Risk Assessment

Planning for a client’s smooth transition to another provider can begin as soon as the client is enrolled (or admitted) for care at your facility. Early assessment and careful planning help ensure that the client is supported across the continuum of care and reduces the risk of adverse events, including avoidable readmissions.

**Table 1. Key Elements of Client Intake and Risk Assessment**

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



### **BEST PRACTICE ALERT: Client Intake and Risk Assessment**

For insured clients without a known PCP and/or behavioral health provider, contact the MCO to see if it has this information. For uninsured clients, consider collaborating with a PCP and/or safety net provider partner such as a community health center or certified community behavioral health clinic to create a workflow to connect clients to care in your community.

### **CARE PATHWAYS<sup>5</sup>**

The aim of a care pathway is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources.

Defining characteristics of care pathways include:

- ▶ An explicit statement of the goals and key elements of care based on evidence, best practice, and patients' characteristics and expectations
- ▶ The facilitation of the communication among the team members, patients and families;
- ▶ The coordination of roles and sequencing of activities of the multidisciplinary care team, the patients and families;
- ▶ Documentation, monitoring, and evaluation of variances and outcomes, and
- ▶ The identification of the appropriate resources.



## 2. Care Plans: Creating and Sharing Among the Care Team

A CARE PLAN is a carefully prepared outline summarizing the client's health care but also his/her needs and the ways of meeting them. It is a dynamic document, and subject to continuous reassessment and change by the staff caring for the patient/client. A properly updated and shared care plan ensures consistency of care; it typically includes diagnoses, interventions, and the client's desired outcomes.<sup>6</sup>

If your organization does not currently create or access a care plan, establish a plan to do so. The table below lists the elements involved in obtaining, creating, and sharing the care plan for your clients.

Table 2. Key Elements of Care Plans				
	Element	Status	Responsible	Timeline
2.1	Obtain the client's care plan from the other providers if a care plan already exists.			
2.2	Create a shareable care plan that includes client's risk level to be sent to other providers involved in the client's care.			
2.3	Involve the client and family in creating and updating the care plan. 			
2.4	Ensure that the care plan is accessible for all care providers using an agreed-upon electronic or (if necessary, manual) process.			



### BEST PRACTICE ALERT: Care Plans

If creating care plans is new for your organization, allocate 30 minutes per patient to develop a care plan until the team learns what information to incorporate. Weekly or biweekly meetings are recommended to review and discuss care plans.<sup>7</sup>

## WAYS OF SHARING CARE PLANS AND OTHER CLIENT INFORMATION

Information transfer between care settings is an important but challenging component of effective transitions of care. Many providers use Electronic Health Records (EHRs) and other health information technologies, but recent studies show that there is significant room for improvement for leveraging these technologies for sharing information both between and within organizations. It is important to be realistic when developing procedures with other providers about sharing client information.

Discussions about how to share the client's care plan and other information should include evaluating the role and feasibility of different technologies including whether information can be shared using:

- ▶ Secure electronic transmission via Direct Messaging (“Direct”). Direct enables providers to securely exchange health care data, including “PHI” via the internet. Access to Direct can be secured via most EHRs and through your regional QE.
- ▶ A secure HIE, or “health information exchange”, or private HIE enabling electronic transfer of or access to client information.
- ▶ A single care management or care coordination platform, wherein users can log into the same health information system.
- ▶ Fax technology.



## 3. Medication Reconciliation

Medication reconciliation is the formal process in which health care professionals partner with clients to ensure accurate and complete medication information transfer at interfaces of care. Adverse drug events are a leading cause of injury and death, and many of these events occur as a result of poor communication between health professionals and between health professionals and clients and/or caregivers when care is transferred, such as when patients are admitted to hospital, move between wards and are discharged home to the community or a residential care facility home.<sup>8</sup>

The basis for effective medication reconciliation is the development, maintenance and communication of a complete and accurate medication list throughout the continuum of care. It is a multidisciplinary activity with responsibilities shared among physicians, nurses, pharmacists, and other clinicians involved in the patient's care. The culture of the organization with respect to interdisciplinary collaboration and teamwork will significantly influence the effectiveness of the medication reconciliation process. The process is best conducted in an environment of shared accountability.<sup>9</sup>

**Table 3. Key Elements of Medication Reconciliation**

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



**BEST PRACTICE ALERT: Medication Reconciliation**

The standard process for reconciling clients' medications include identifying and documenting:

1. How frequently reconciliation will occur,
2. Staff who will perform the reconciliation,
3. Staff responsibilities in the process, and
4. Instruments to be used in the reconciliation process.

If discrepancies are found, processes are needed to:

1. Determine the client's medication regimen going forward,
2. Effectively communicate a new medication regimen to clients and families and to all members of the treatment team and
3. Document changes in the medical record and the basis for these changes.

The plan may also identify resources outside the agency that may contribute to the effort (e.g. enlisting pharmacists to assist in detecting discrepancies).

## 4. Social/Resource Barriers Assessment and Links to CBOs

Social determinants of health have been defined as the circumstances in which people are born, grow up, work and age, and the systems put in place to deal with illness. These circumstances lead to health inequities -- the unfair and avoidable differences in health status between groups of people. These health inequities greatly influence the risk of illness and the actions taken to prevent people from becoming ill or treat illness when it occurs. The drivers of health inequities include: income, education, occupation, employment opportunities, gender, race/ethnicity and other factors.<sup>10</sup>

Health care organizations are pursuing partnerships with community-based organizations (CBOs) — e.g., housing organizations, workforce development agencies, food banks, and early childhood education providers — to meet both the medical and social needs of the populations they serve. Locally based CBOs are well positioned to identify and address unmet social needs since they are so closely connected to the populations they serve and familiar with the environments in which they live and work. Through care coordination and the integration of social needs assessments, medical and behavioral health providers can partner with CBOs in their communities to address a broad range.<sup>11</sup>

**Table 4. Key Elements of Social/Resource Barriers Assessment and Links to CBOs**

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

## 5. Client and Family Engagement

Client and family engagement calls upon providers to proactively involve clients and their families in the definition, design, and delivery of their care. This means ensuring that clients and families are knowledgeable about their condition and plan of care, indications that their condition is worsening, and how to respond to “red flags”. Practices should educate clients using appropriate health literacy materials and language, “translating” information between the provider and patient to ensure that each really understands what the other has communicated. In addition, providers are encouraged to use the teach-back process around specific risk issues, to verify the client’s understanding of the information, and asking them to explain the details of the plan in their own words.<sup>12</sup>

**Table 4. Key Elements of Social/Resource Barriers Assessment and Links to CBOs**

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

## PART B. TRANSITION

The actual coordination of client services between providers can present multiple challenges. Providers sharing accountability for care and outcomes should agree on the expectations and responsibilities for the practices involved in a referral relationship, and can do so using a care coordination agreement. These agreements can address tasks including scheduling the follow-up appointment and handing off client treatment and plan information, as well as methods of communication, and expected patient engagement activities. Links to sample Care Coordination Agreements appear in the [Additional Resources Section](#).



### BEST PRACTICE ALERT: Responsibility Matrix

One technique for determining roles and responsibilities across different organizations that share accountability for client care and outcomes is the [RACI matrix](#). Consider using the RACI matrix to facilitate focused and systematic discussions to identify and clarify roles and responsibilities among those caring for clients.<sup>13</sup>

## 6. Scheduling the “Follow-Up” Appointment and Other In-Person Future Contacts

For the purposes of this Guide, follow-up appointments refer to post-discharge appointments with community-based providers, as well as other kinds of in-person future provider contacts a client may need. Examples include referrals between outpatient behavioral health and primary care providers, return visits to the same provider (e.g., for a 2-week check-in), or assignments to CBOs to address non-clinical service needs.

**Table 6. Key Elements of Scheduling the “Follow-up” Appointment and Other In-Person Future Contacts**

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

	Element	Status	Responsible	Timeline
6.3	Document the follow-up appointment details in the care plan, and attach any relevant tests.			
6.4	Provide practical information (see information box below) to client and/or family about the next appointment, and provide documentation of this, as appropriate.			

### WHAT PRACTICAL INFORMATION SHOULD BE REINFORCED?

Any information the client and his/her family needs to have to keep appointments should be reinforced and documented, including:

- ▶ The purpose and importance of the follow-up appointment
- ▶ Any details regarding payment or insurance
- ▶ Office location, directions, and any other logistics (e.g., parking)
- ▶ Confirmation of available resources to attend the appointment (child care, transportation, time off)
- ▶ Reminder to bring appropriate documentation to the appointment
- ▶ How to reschedule if the schedule time does not work



## 7. The Warm “Handover”

To be successful, these types of client “handovers” call upon the members across different organizations to clarify exactly which organization, and the person (or role) in that organization, is charged with completing the various steps. This requires organizations to discuss and agree upon key processes in the care pathways they use to manage clients.

**Table 7. Key Elements of Client Handover**

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

## PART C. FOLLOW-UP POST TRANSITION

### 8. Follow-Up Phone Call or Other Remote Contact

Practices need processes to ensure that both outbound and inbound telephonic and/or other electronic contacts with clients and families work as well as possible. Clients typically have smartphones, and many prefer to be reached that way including by text.

**Table 8. Key Elements of Follow-up Phone Call or Other Remote Contact**

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



#### BEST PRACTICE ALERT: Follow-up Phone Call

Some EHRs enable automated phone or text reminders for upcoming appointments.

#### REMINDER CALLS

- ▶ Confirm date, time, provider name and location of appointment
- ▶ Check client transportation and child care if applicable
- ▶ Offer assistance if the client needs to change the appointment or identifies barriers
- ▶ Encourage the client to arrive on time, and to bring any medications, insurance information, and a list of questions for the provider



## 9. Follow-up Appointment — Outpatient Provider Visit

Outpatient community-based practices are often on the receiving end of the referral from another provider in the continuum of care. At the same time, they in turn are often generating further referrals for the client, or setting up their own future follow-up appointments.

**Table 9. Key Elements of Follow-up Appointment**

	Element	Status	Responsible	Timeline
9.1	Allow sufficient appointment time for a thorough examination and to address post-discharge (if applicable) follow-up items including access to medication.			
9.2	Engage clients in goal setting and shared decision making. 			
9.3	Provide opportunities for the client/caregiver to ask questions.			
9.4	Utilize a checklist/assessment to ensure that all needed follow-up conversations and services occur.			
9.5	Schedule any future/follow-up appointments as appropriate following elements in <a href="#">Section 6</a> above.			
9.6	Establish a process to inform the referring provider of the outcome of the visit.			

## 10. Feedback for Quality Improvement

An important part of implementing a process to achieve successful transitions of care is ongoing evaluation. The evaluation should consist of a deliberate, systematic effort to determine whether the goals of the effort have been met and identify opportunities to improve. The QI process should be both quantitative and qualitative, enabling participants to understand the number and proportion of clients with successful transitions, as well as how the process of transition was experienced by the client, family, and the providers involved.

Note that as stated in the “[Getting Started](#)” section of this Guide, it is important to set goals *early* on in your work to improve transitions of care. This will enable you to focus on and communicate throughout your organization what exactly you are trying to achieve in concrete terms everyone can relate to.

### MEASURES AND METRICS RELATED TO TRANSITIONS OF CARE.

Many measures exist to evaluate the elements of transitions of care cited in this Guide: they capture performance related to notification of inpatient admission, medication reconciliation post-discharge, avoidable admissions or readmissions, community-based follow-up post discharge, preventable ER visits, availability of discharge instructions, effective appointment scheduling, and more. Federal and state regulatory bodies, national workgroups, health plans and other stakeholders have identified and continue to refine and add to the list. The Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), and the National Committee for Quality Assurance (NCQA) are but a few entities that have validated, promoted, and/or required the monitoring of such measures.

For users of this Guide seeking to evaluate whether their practice is improving transitions of care, choose measures that are most relevant to your practice, and for which data can be feasibly collected, stored, analyzed, and reported on.

**Table 10. Key Elements of Feedback for Quality Improvement**

	Element	Status	Responsible	Timeline
10.1	Identify SMART goals for improving transitions of care in your organization.			
10.2	Establish a system/mechanism to measure performance based on identified SMART goals; specify data sources and who is responsible for collecting, reporting and reviewing the data collected.			
10.3	Systematically review a random sample of readmission cases for quality improvement purposes.			

	Element	Status	Responsible	Timeline
10.3	Create a forum between hospitals, community providers, clients and their families to review the feedback together and establish process to improve transitions of care.			
10.4	Implement changes to the transitions of care processes based on feedback and performance on identified metrics.			

Importantly, the QI process calls upon providers to adjust their processes as they get feedback from clients and families, community partners, and evaluate their performance on their metrics. Quality improvement is a continuous process; techniques like PDSA (Plan-Do-Study-Act) can be used to try new approaches.

### WHAT ARE SMART GOALS?

- ▶ Specific
- ▶ Measurable
- ▶ Achievable
- ▶ Realistic
- ▶ Time-Bound

**HAVE QUESTIONS?** 

Contact us at  
[Consulting@thenationalcouncil.org](mailto:Consulting@thenationalcouncil.org)

# ADDITIONAL RESOURCES

## TRANSITIONS OF CARE PLANNING

- [AHRQ Data Analysis Tool](#) – This spreadsheet facilitates data analysis and interpretation to compare and contrast readmission patterns by payer.
- [AHRQ Portfolio Design Tool](#) – This PowerPoint deck includes examples of readmission reduction portfolios that can be modified to develop the data-informed, multifaceted portfolio of readmission reduction efforts in your hospital.
- [AHRQ Operational Dashboard Tool](#) – This PowerPoint deck provides an example of an operational dashboard to track measures of monthly discharge volume, monthly implementation measures, and monthly outcomes (readmission rates).
- [AHRQ Portfolio Presentation Tool](#) – This PowerPoint deck summarizes the findings of the quantitative and qualitative data review, hospital and community inventory, aim, target population, and data-informed strategy to reduce readmissions.
- [AHRQ Discharge Process Checklist Tool](#) – This tool, adapted from the CMS COPs, provides a checklist of discharge elements that CMS states should be provided to all Medicare and Medicaid patients. This tool can be used to update existing processes and identify whether new processes and practices need to be implemented.
- [AHRQ Cross-Continuum Collaboration Tool](#) – This tool helps teams develop specific effective and timely linkages to services with cross-continuum clinical, behavioral, and social service providers.
- [Transitions of Care Protocol Mapping](#) – An example protocol for care transitions.

## RISK ASSESSMENT

- [Patient Health Questionnaire \(PHQ-9\)](#) – A common screening tool used to identify depression.
- [AUDIT-C](#) – a 3-question screening tool used to identify hazardous or harmful drinking.
- [GAD-7](#) – a 7-question screening tool used to identify whether a complete assessment for anxiety is needed.
- [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#) – A screening tool use to assess suicidality.
- [SAMHSA-HRSA Center for Integrate Health Solutions Screening Tools](#) – Additional screening tools to identify mental health and/or substance use problems.

## CARE PATHWAYS

- [Care Transitions Network Risk Stratification Tool](#) – An Excel workbook that enables providers to stratify risk, identify trends, and track outcomes over time at the population level
- [Risk Stratification Tool and Chronic Conditions Financial Calculator User Guide](#) – Guidance on how to use the risk stratification tool

## ONGOING PROVIDER INFORMATION

- [AHRQ Hospital Inventory Tool](#) – This tool prompts a comprehensive inventory of readmission reduction activity and related organizational and operational assets across departments, service lines, and units within the hospital.

## CARE PLAN

- [AHRQ ED Plan Examples](#) – Emergency department care plan template and examples of ED care plans.

## MEDICATION RECONCILIATION

- [WHO's the High 5s Project Standard Operating Protocol: Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation](#)
- Medication List:
  - [AARP My Personal Medication Record](#) – A resource for patients to track medications and help health care providers and pharmacists have the most current information
  - [FDA My Medicine Record](#)

## SOCIAL/RESOURCE BARRIERS ASSESSMENT

- [PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences](#) – The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS). PRAPARE emphasizes measures that are actionable.
- [AHRQ Whole-Person Transitional Care Planning Tool](#) – Prompts to help discharge planners identify readmission risks and to take steps to ensure those risks are addressed in the transitional care (discharge) plan.
- Creating an inventory of community resources:
  - [AHRQ Community Inventory Tool](#) – A tool to prompt an inventory of post-acute and community-based providers, agencies, and plans that can offer posthospital services.
  - [AHRQ Community Resource Guide Tool](#) – A two-part tool: a community resource guide and a one-page “quick reference” version.

## CLIENT AND FAMILY/CAREGIVER ENGAGEMENT

- [Health Literacy Universal Precautions Toolkit: Use the Teach-Back Method](#)
- [AMA Health Literacy and Patient Safety: Help Patients Understand – Manual for Clinicians](#)
- [NTOCC's Guidelines for a Hospital Stay Brochure](#) – A brochure to help guide patients, families, and caregivers on how to provide safe and successful health care at the hospital.
- [Consumers Advancing Patient Safety \(CAPS\) Care Transitions Toolkit](#) – A toolkit to help patients and families collect the information they'll need to make a smooth transition from the hospital to their next destination.
- [Tools for Family Caregivers](#) – A list of resources and educational materials for family caregivers compiled by The National Family Caregivers Association.
- [Project RED: Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge](#) – A tool highlighting the roles and needs of family caregivers in the hospital so that they are partners in improving transitions and reducing readmissions.

- [Recommendation for Physicians to Facilitate a Patient-centered Discussion with a Patient](#) – A set of recommendations, by the American College, of Physicians to help referring physicians and other healthcare professionals engage in an effective “patient- and family-centered” referral process.
- [Care About Your Care Discharge Checklist & Care Transition Plan](#) – A tool to help patients and caregivers keep track of their care plan after leaving the hospital.

## SCHEDULING THE FOLLOW-UP APPOINTMENT & CLIENT HANDOVER

- Sample Care Coordination Agreements
  - [Agreement Between Primary Care Practice and Hospital Care Team](#)
  - [Agreement Between Primary Care Physician and Subspecialist](#)
  - [Qualis Health Referral Agreement Template](#)
  - [Actual Care Compact Example](#)
  - [Mesa County Physicians IPA Care Coordination Agreement Referral Form](#)
- [TCPi and WCAAP Pediatric Provider Toolkit: Primary Care and Behavioral Health](#) – Templates and best practices for increasing communication between primary care providers and behavioral health providers about specific patient care.

## FOLLOW-UP PHONE CALL

- [Project RED: How to Conduct a Post-Discharge Follow-up Telephone Call](#) – A script for follow-up telephone calls, scenarios of actual calls, and a role play exercise that can be used in training callers.

## FOLLOW-UP APPOINTMENT – OUTPATIENT PROVIDER VISIT

- [The Post-Hospital Follow-up Visit: A Physician Checklist to Reduce Readmissions](#)

## FEEDBACK FOR QUALITY IMPROVEMENT

- [AHRQ Readmission Review Tool](#) – Adapted from the well-known STAAR approach, this 1-page interview guide prompts clinical or quality staff to elicit a recounting of what happened between discharge and readmission from the patient/caregiver perspective.

## OTHER

- [AHRQ’s Hospital Guide to Reducing Medicaid Readmissions](#)
- [NTOCC Care Transitions Bundle: Seven Essential Intervention Categories](#)
- [Reducing Readmissions: Care Transitions Toolkit©, 3rd Edition](#)
- [NYS Office of Mental Health Reducing Behavioral Health Readmissions: Strategies and Lessons Learned](#)
- [Project RED \(Re-Engineered Discharge\)](#)
- [Closing the Referral Loop: A toolkit to improve the referral management process between primary care and specialist physicians](#)
- [Project BOOST Implementation Guide - Better Outcomes by Optimizing Safe Transitions](#)

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