Transitional Care Checklist

Key elements to include when implementing a hospital readmission reduction initiative

☐ **Getting Started – Data and Measures**

- Calculate the readmission rate for your patients and identify any upward or downward trends
- Review Anthem reports to identify patients who are currently hospitalized or who have been hospitalized and discharged within the last 30 days, those with 'Med Erratic Refill' chronic care gaps, and the Care Op report for medication adherence and high risk medications
- Leverage reports to determine readmission risk of patients
- Prioritize patients by hospital readmission risk and create the intervention (full vs. modified)

☐ **Establish Protocol for Transitional Care**

- Define success by creating SMART goals (Specific, Measurable, Actionable, Realistic, Timely)
- Establish and communicate the goals and expectations for Transitional Care to all providers in the practice
- Select Transitional Care measures for tracking
- Create/update practice Data Wall for provider and care team communication
- Determine top 3 hospitals and Skilled Nursing Facilities that care for your patients and establish Transitional Care Compacts
- Create and implement protocol and workflow for managing Transitional Care in your office
- Implement registries for patient outreach, managing unresponsive patients, sending reminders for office visits, etc.
- Build local resource library for patients

☐ **Assess Access**

- Consider implementing advanced access measures, possibly adapting the clinic approach to offer a designated day/time to Medication patients, including extended office hours and offering same day visits
    - Clinic approach (designated day/period of time to Medicare Patients)
    - Extended hours
    - Advanced access (same day visits)
- Perform supply and demand analysis, if needed
- Determine patient transportation challenges/barriers
- Offer home visit and Tele-medicine options to patients who are home bound or have transportation challenges

☐ **Establish Comprehensive Medication Management Strategy**

- Implement strategy for Medication Reconciliation
- Revisit medications during all follow-up visits and assess for adherence barriers and adverse events
- Identify and implement a medication management tool

☐ **Establish Protocols for Pre-visit, Visit and Post-visit planning**

- Leverage Anthem's Pre-visit, Visit, Post-visit Planning Worksheet and Patient Activity Tracker
- Establish team-based care protocols
- Leverage care team huddles (review P-360 Patient Summary)
- Ensure evidence-based guidelines and Health Risk Assessments (HRAs) are in place

☐ **Perform Ongoing Monthly Assessment**

- Recalculate readmission rate and determine if your rates are trending upward or downward
- Determine what is working and what is not working for Transitional Care programming

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Key elements of the patient's follow-up visit with their PCP

☐ **Conduct Transitional Care Office Visits**

- Discuss hospitalization with patient and review discharge instructions
- Review patient's medications, identify high-risk medications, perform medication reconciliation and determine adherence and capacity for medication self-management; ensure patient can obtain medications
- Take vitals and conduct physical exam; obtain patient reported health status and determine ability to self-manage care
- Discuss dietary restrictions, nutrition and exercise
- Conduct screenings for Behavioral Health depression, self-management abilities, and fall risk
    - Review Health Alert cards and create emergency plan; provide patient with Contact List of all their providers
- Complete patient education, share materials, and confirm patient understanding
- Determine ongoing support that is needed; e.g., counseling, physical therapy, home visits
- Patient meets with Care Coordinator for Care Planning and identifying barriers to care and gaps in care; sign Care Agreement and share resources from Resource Library with the patient
- Follow-up and monitor Care Plan and patient's progress; schedule Specialist visits and future PCP visits

☐ **Perform Annual Review**

- Trend readmission rates for the year
- Review and modify Transitional Care Compacts as needed and review data for Transitional Care measures being tracked
- Review and modify workflows and policies as needed