Transitional Care Protocol

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Patient Signature   Date

This protocol outlines the process for caring for transitioning patients.

Process Name	Date the process will be performed	How the process will be performed
Hospital/SNF Discharge		
Pre-discharge consultation		
Initial contact with PCP		
Scheduling of initial follow-up appointment with PCP		
Faxing discharge instructions to PCP		

PCP Follow-up		
If first follow-up visit is > 48 hours post discharge, telephone patient and • Discuss discharge instructions and get self-reported health status • Uncover transportation challenges; connect with transportation resources • Collect contact information for family members/caretakers		
Determine follow-up schedule for additional phone calls or mailings (discharge summary), list of upcoming appointments listing all providers – (cc: Caretakers)		

Process Name	Date the process will be performed	How the process will be performed
PCP Follow-up 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 Card(s), create emergency plan, and provide patient with Contact List		
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, sign Care Agreement and share resources from Resource Library with patient		
Schedule Specialist and future PCP visits		
Follow-up and monitor Care Plan and patient's progress		