



## APPENDIX C Elements of Excellence in Transitions of Care (TOC)

### TOC Checklist

\*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and other essential clinical information. The checklist can serve as an adjunct to each provider’s assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient’s record. Every element on this checklist may not be relevant to each provider or setting.

\*For purposes of brevity, the term *patient/client* is used throughout this checklist to describe the client and client system (or patient and family). The *patient/client system* (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client’s informal support network. Depending on the setting in which this checklist is used, providers may wish to substitute *resident, consumer, beneficiary, individual*, or other terms for *patient/client*.

### Overarching Concepts

#### **Engagement**

- Maximize patient/client involvement in all phases of intervention by promoting self-determination and informed decision-making.
- Provide educational information to support the patient/client’s participation in the plan of care.
- Protect patient/client’s right to privacy and safeguard confidentiality when releasing patient/client information.
- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess and promote the patient/client’s efforts to participate in the plan of care.

## **Collaboration**

- Define multidisciplinary team participants.
- Build relationships with all team members, with the patient/client at the center of the collaborative model.
- Communicate with other professionals and organizations, delineating respective responsibilities.
- Create awareness of patient/client and provider accountability for receiving and sending patient/client care information to and from care settings.
- Provide services within the bounds of professional competency and refer patient/client as needed.

## **Strengths-based assessment**

- Use respect and empathy in patient/client interactions.
- Recognize patient/client's strengths and use those abilities to effect change.
- Help patient/client use effective coping skills and insights to manage current crises.
- Recognize and help resolve patient/client's difficulties.
- Distinguish cultural norms and behaviors from challenging behaviors.

## **Assessment as an ongoing process**

- Keep assessments flexible, varying with presenting problem or opportunity.
- Regularly reassess patient/client's needs and progress in meeting objectives.
- Facilitate goal-setting discussion based upon the patient/client's needs during all phases of care.
- Assess effectiveness of interventions in achieving patient/client's goals.
- Communicate changes in assessment and care plan to the health care team.

## **Common Elements for Assessment and Intervention**

### **Physiological functioning**

- Assess patient/client's understanding of diagnosis, treatment options, and prognosis.
- Evaluate patient/client's life care planning and advance directive status.
- Evaluate impact of illness, injury, or treatments on physical, psychosocial, and sexual functioning.
- Evaluate patient/client's ability to return to or exceed pre-illness or pre-injury function level.

### **Psychosocial functioning**

- Assess past and current mental health, emotional, cognitive, social, behavioral, or substance use/abuse concerns that may affect adjustment to illness and care management needs.
- Assess effect of medical illness or injury on psychological, emotional, cognitive, behavioral, and social functioning.

- Determine with patient/client which psychosocial services are needed to maximize coping.

### **Cultural factors**

- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess cultural values and beliefs, including perceptions of illness, disability, and death.
- Use the patient/client's values and beliefs to strengthen the support system.
- Understand traditions and values of patient/client groups as they relate to health care and decision-making.

### **Health literacy and linguistic factors**

- Provide information and services in patient/client's preferred language, using translation services and interpreters.
- Use effective tools to measure patient/client's health literacy.
- Provide easy-to-understand, clinically appropriate material in layperson's language.
- Use graphic representations for patients/clients with limited language proficiency or literacy.
- Check to ensure accurate communication using teach-back methods.
- Develop educational plan based upon patient/client's identified needs.
- Evaluate caregiver's capacity to understand and apply health care information in assisting patient/client.

### **Financial factors**

- Identify patient/client's access to, type of, and ability to navigate health insurance.
- Identify patient/client's access to and ability to navigate prescription benefits.
- Evaluate impact of illness on financial resources and ability to earn a living wage.
- Provide feedback on financial impact of treatment options.
- Educate patient/client about benefit options and how to access available resources.
- Assess barriers to accessing care and identify solutions to ensure access.

### **Spiritual and religious functioning**

- Assess how patient/client finds meaning in life.
- Assess how spirituality and religion affect adaptation to illness.

### **Physical and environmental safety**

- Evaluate patient/client's ability to perform activities of daily living and meet basic needs.
- Assess environmental barriers that may compromise the patient/client's ability to meet established treatment goals.
- Determine with patient/client the appropriate level of care.
- Assess ability of family or other informal caregivers to assist patient/client.

- Assess for risk of harm to self or others.

**Family and community support**

- Identify patient/client’s formal and informal support systems.
- Assess how patient/client’s illness affects family structure and roles.
- Provide support to family members and other informal caregivers.
- Assess for, and if appropriate help resolve, conflicts within the family.
- Evaluate risk of physical, emotional, or financial abuse or neglect, referring to community social services as needed.

**Assessment of medical issues**

- Patient/client diagnosis
- Symptoms
- Medication list and reconciliation of new medications throughout treatment
- Adherence assessment and intention
- Substance use and abuse disorders
- Lab tests, consultations, x-rays, and other relevant test results

**Continuity/Coordination or Care Communication**

- Specific clinical providers
- Date information sent to referring physician, PCP, or other clinical providers
- Necessary follow-up care

**Example of Assessment & Coordination of Care Communication Checklist & Tool**

**Medication Assessment:**

- Review all prescribed medications, over-the-counter medications, and health/nutritional supplements

Name of Medication

Dose

Route

Frequency

Next Refill

Can the patient/client tell you:

Reason she or he is taking medication

Positive effects of taking medication

Symptoms or side effects of taking medication

Where the medication is kept at home

The next refill date for the medication

How long she or he needs to remain on the medication

Modified Morisky Scale – a validated, evidence-based tool (Morisky 1983)

<b>Question</b>	<b>Motivation</b>	<b>Knowledge</b>
1. Do you ever forget to take your medicine?	Yes(0) No(1)	
2. Are you careless at times about taking your medicine?	Yes(0) No(1)	
3. When you feel better do you sometimes stop taking your medicine?		Yes(0) No(1)
4. Sometimes if you feel worse when you take your medicine, do you stop taking it?		Yes(0) No(1)
5. Do you know the long-term benefit of taking your medicine as told to you by your doctor or pharmacist?		Yes(1) No(0)
6. Sometimes do you forget to refill your prescription medicine on time?	Yes(0) No(1)	

**Table 4. Modified Morisky Scale (1)**

*1. CMAG 2006*

**Hand off all assessments to the next level of care coordination**

**CONTINUITY/COORDINATION OF CARE:**

Y N	Does the patient/client have a primary care physician? (if appropriate) Send assessment information to PCP – Date
Y N	Does the patient/client have a specialty physician, e.g., cardiologist? (if appropriate) Send assessment information – Date
Y N	Does the patient/client have a psychiatrist or other mental health provider? (if appropriate) Send assessment information – Date
Y N	Does the patient/client have an outpatient case manager who should be notified? Send assessment information – Date
Y N	Ensure all transition services and care (medications, equipment, home care, SNF, hospice) are coordinated and documented – Date verified
Y N	Ensure patient/client and caregiver understand all information and have a copy of the care plan with them – Date verified

## Glossary

<b>Advance directive</b>	Describes two types of legal documents, a living will and medical power of attorney (also called a health care proxy or agent), that enable an individual to plan for and communicate her or his end-of-life wishes in the event that she or he is unable to communicate
<b>Care coordination</b>	Process that typically encompasses the assessment of a patient/client's needs, development and implementation of a plan of care, and evaluation of the care plan
<b>Clinician</b>	Health professionals who come into contact with patients/clients, including physicians, nurses, social workers, pharmacists, physician assistants, dieticians, physical therapists, and occupational therapists
<b>Health literacy</b>	The ability to read, understand, and act on health information. Poor health literacy can cause medication errors, impair one's ability to remember and follow treatment recommendations, and reduce one's ability to navigate the healthcare system.
<b>Mental health provider</b>	Professional, such as a social worker, psychiatric nurse, psychologist, psychiatrist, or licensed counselor, who provides one or more of a variety of mental health services
<b>Misuse</b>	Failure to achieve full benefit of an appropriate treatment or service due to preventable complication or misapplication of care
<b>Overuse</b>	Providing a medication or other type of care when the potential harm is greater than the potential benefit
<b>SNFists</b>	Primary care physicians who spend a substantial portion of their practice caring for postacute or subacute patients/clients in skilled nursing facilities
<b>Transitional care</b>	Care involved when a patient/client leaves one care setting (i.e. hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moves to another
<b>Underuse</b>	Failure to provide a service, such as medications or preventive services, which would have produced a favorable outcome for a patient