ORGANIZATIONAL SELF-ASSESSMENT

TRANSITIONS OF CARE

STANDARD 2.0 Complete a Comprehensive Transition Assessment

Processes are in place to conduct a comprehensive transition assessment for patients identified as high-risk for ineffective transitions across care settings. Attention is given to further identify patients who may become at risk in the new setting due to physical, mental, or social barriers during transition from one setting to another.

Show evidence that the comprehensive transition assessment is completed and that the following elements are included:

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	Score
Review of relevant health care utilization across all settings including recent provider orders, payor benefits, preferred networks, and claims data when available (including assessment of community based organizations supporting social barriers, i.e., transportation support, food banks, etc.).					
Solicit patient, family, and caregiver goals for care transitions for settings and levels of care. Assess the patient's living setting prior to transition for eventual discharge home (i.e., group home, Jail, LTC facility, homelessness, etc.).					
Evaluate and document patient/family/caregiver engagement and understanding of current health status.					

Assess self-management abilities, which may include activities of daily living (ADL), instrumental activities of daily living (IADL), patient's decision-making ability, and/or willingness to participate in care planning discussions.					
Comprehensive review of social drivers of health risk factors and status, noting risk factors.					
Complete a medication reconciliation and assess medication adherence.					
Review and document patient care goals according to the regulations that govern the caresetting and, when appropriate, identify the patient's designated decision maker.					
Examination of advance care planning documents ensuring they are current, and complete and available to the health care team.					
Communication of assessment summary and plan of care to provider, health plan, and health care team, and to the next care setting.					
				Standard 2.0 Organization Score:	

Consensus Measures

Process: Receipt of discharge information immediately following discharge (HEDIS)

Outcome: Evidence of advance care planning documentation (CMS IQR/OQR 0326)

Consistently is defined as performance of service/task **80% of greater**	**Frequently** is defined as performance of service/task **50% - 79%**	**Inconsistently** is defined as performance of service/task **20% - 49%**	**Not performing** is defined as performance of service/task **less than 20%**