# Wrench and hammer tool logo  Tool 9: Whole-Person Transitional Care Planning Tool

### Purpose

The social, economic, and geographic conditions in which individuals live have a profound impact on individuals’ health status. Efforts to reduce readmissions by optimizing self-management or long-term health status will predictably fail for individuals whose pressing fundamental survival needs are not met.

Prompt recognition of complex nonclinical (“social” needs), such as housing, transportation, and social support, can greatly affect the likelihood that those needs can be addressed, rather than deferred, prior to discharge. This task will often require going well beyond the brief “social history” that is contained in the physician’s admission history and physical.

Furthermore, reliable identification of these needs is necessary but not sufficient to reduce readmissions. The ‘active arm” of efforts to reduce readmissions is in ensuring a successful linkage to the anticipated range of care and support services after discharge. The easier it is to “see a problem, fix a problem,” the easier it will be for your hospital staff to execute a safe, effective transition reliably for your patients.

### Description

This tool provides discharge planners with a set of prompts to identify readmission risks and to take steps to ensure those risks are addressed in the transitional care (discharge) plan.

### Staff

Day-to-day readmission reduction champion to test, adapt, and incorporate into existing workflow with frontline staff.

### Time Required

Incorporate into regular discharge planning assessment and referrals.

### Additional Resources

See Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for more information on implementing a reliable, whole-person transitional care process, and **Tool 11: Community Resource Guide** for community resource information that can be used to populate the right side of the Whole-Person Transitional Care Planning Tool.

## Tool 9: Whole-Person Transitional Care Planning Tool

Readmissions rarely result from a singular breakdown in the transition of care and posthospital supports. A team at Kaiser Permanente in Northern California reviewed more than 500 adult readmissions (all payer, all ages) from across 18 of their hospitals. Among 250 readmissions they deemed to be potentially avoidable, an average of 9 factors contributed to each readmission.[[1]](#footnote-1)

The message from this person-centered view of readmissions is that no single issue defines readmission risk. Take a “whole-person” view of transitional care and ongoing care needs to better identify not only risk of readmission, but also transitional care services and supports needed to address those needs so you can minimize readmission risk.

As is evident by the many domains on this assessment form, it can be a valuable tool for not only hospital discharge planners, but also for “receiving” providers and agencies in postacute and community-based settings. Best practice is to share this assessment with “receiving” providers in the community. As your cross-continuum team gains experience with whole-person, cross-setting assessment, you may be able to gain efficiencies when patients return to the hospital and this comprehensive view of their needs has already been completed and is shared with the inpatient team from the outpatient setting.

# Whole-Person Care Transitional Planning Tool

### Readmission Risks and/or Posthospital Needs

Uncover patient’s nonclinical issues and challenges in accessing posthospital care to prevent avoidable hospitalizations in the future.

Access to Ambulatory Care

* No regular source of care
* Difficulty with transportation to medical care
* Work/family responsibilities that pose barrier to appointments
* Regular use of emergency room for care

Access to Behavioral Health Care

* History of receiving behavioral health services
* Concern about emotional or mental health
* Alcohol or drugs affecting health and wellness
* Needs linkage to behavioral health services

Functional Status

* Functional limitations
* Cognitive limitations, including executive function
* Low self-activation or self-efficacy
* Disabled, may qualify for Aging and Disability Resource Center or other services

Unstable/Inadequate Housing

* Lack of stable housing
* Lack of heat or cooling
* Environmental hazards affecting health (mold, etc.)
* Lack of safety and security within or outside the home

Financial Insecurity

* Difficulty paying for basic survival needs (shelter, food)
* Difficulty paying medical-related costs (copays, supplies)
* Must prioritize survival versus medical needs

Food Insecurity/access

* Lacks access to adequate amounts of food
* Lacks access to nutritious or medically appropriate diet

Social Connection/Isolation

* Lives alone
* Lacks friends/family/connections

Legal Issues

* Barriers due to insurance coverage, utilities, pending eviction
* Recent or repeated incarceration or detention

Language or Literacy Issues

* Low literacy, low numeracy
* Low health literacy—diagnoses, medications, care plan
* Low or no ability to speak English

### Actions to Take Prior to Discharge

Use the improvement motto, “See a problem, fix a problem.” This list represents possible interventions you may identify for a patient. Modify it to meet the most common needs for your patient population.

Interdisciplinary Care Planning and Coordination

* Obtain high-risk readmission team consult
* Contact an MCO, ACO, PCMH, health home care manager, as applicable
* Contact community clinical, behavioral, and social service providers
* Obtain pharmacist consult
* Obtain social work consult
* Obtain pain management or palliative care consult, as applicable
* Obtain psychiatry consult, as applicable
* Develop individualized transitional care plan
* Share plan with ED, outpatient providers, community service providers

Provide Services

* Identify whether eligible for (Medicaid) health home and contact health home to initiate screening and enrollment process
* Contact MCO, ACO, PCMH, health home medical director if high-risk patient is not currently in care management to advocate for enhanced services
* Arrange for bedside delivery of medications
* Discuss cost of medications, how patient will obtain them; modify as needed
* Discuss transportation and arrange as needed
* Offer to provide transitional care followup services (if available)

Arrange for Next Steps

* Ensure all patients have a primary care provider or temporary provider (“bridge” clinic)
* Schedule followup with primary care provider
* Schedule followup with relevant specialists
* Schedule followup with behavioral health provider
* Initiate initial eligibility screen for services (health home, adult day, etc.) or allow social/support service entity to screen patient prior to discharge
* Ask for best contact number for purposes of postdischarge followup call

Link to PostHospital Supports and Services

* Link to transitional care navigating and support services for 30 days
* Link to community behavioral health services
* Link to community health worker or navigator programs
* Link to housing with services agency
* Link to food program
* Link to county health department provided services
* Link to community/faith-based or volunteer services
* Link to Medical-Legal Partnership
* Link to adult day health services
* Link to language-concordant navigation or advocacy services
1. Feigenbaum P, Neuwirth E, Trowbridge L, Teplitsky S, Barnes C, Fireman E et al. Factors Contributing to All-cause 30-day Readmissions. Medical Care. 2012;50(7):599-605. Accessed July 28, 2016. [↑](#footnote-ref-1)