Identify the stage of implementation for each structure/process within your community-based palliative care program. Please check the category most aligned with the stage of implementation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Structure | Process | Stage of Implementation | | |
| Planning | Executing | Evaluating |
| **Multidisciplinary team** | Identify team positions and roles |  |  |  |
| **Community map of services** | Survey community care providers and services to meet gaps in care |  |  |  |
| **Map of clinical care settings** | Survey care settings where patients can receive clinical care |  |  |  |
| **Transitions of care plan** | Procedures to inform clinical team’s care process for patient’s care transitions |  |  |  |
| **Medication assessment** | Review all prescribed medications to prevent medication errors and polypharmacy |  |  |  |
| **Care coordination agreement among providers** | Mechanism to ensure information flow and sharing of care responsibilities for patient among care providers |  |  |  |
| **Barriers to care map** | Identify care access points where patient and family/caregiver can become vulnerable to overall poor health care quality outcomes |  |  |  |
| **Patient-centered care** | Treatment plan is aligned with patient and family/caregiver goals and preferences, travels with patient between care settings |  |  |  |
| **Self-care management protocols** | Patient and family/caregiver receive information that is useful, clear, and understandable, enforced by teach-back method |  |  |  |
| **Discharge preparation checklist for clinicians** | Mechanism to prevent hospital readmissions and patient’s safe tenure in community setting of choice |  |  |  |
| **Discharge preparation checklist for patient** | Mechanism to prevent hospital readmissions and patient’s safe tenure in community setting of choice |  |  |  |
| **Patient and family/caregiver care transitions report card** | Mechanism in place to assess effectiveness of transitions of care plan in achieving patient and family/caregiver goals |  |  |  |

\*Adapted from Quality Connections Care Coordination. National Quality Forum. October 2010.