Minimum Standard Data Set for A Care Transition

Care transitions refer to the movement of patients from one health care provider or setting to another. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community. One element for a safe, effective and efficient care transition should be standardized and accurate communication and information exchange between the transferring and receiving provider in time to allow the receiving provider to effectively care for the patient.

Standard information that should be provided across care settings include:

- Principle diagnosis and problem list
- Reconciled medication list including over the counter/herbals, allergies and drug interactions
- Clearly identified medical home/transferring coordinating physician/provider/institution and their contract information
- Patient's cognitive status
- Test results/pending results
- Pertinent discharge instructions
- Follow up appointments
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Preferences, priorities, goals and values, including care limiting treatment orders (e.g., DNR) or other end-of-life or palliative care plans

In addition, the "ideal" transfer records would also include:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Planned interventions, durable medical equipment, would care, etc.
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transitions record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive