



Model	Description
<p>Care Transitions Program http://www.caretransitions.org Eric A. Coleman, MD, MPH</p>	<p>During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a Transition CoachTM to learn self-management skills that will ensure their needs are met during the transition from hospital to home.</p> <p>Care Transitions InterventionSM is a self-management model</p> <p>The Care Transitions ProgramSM worked with older adults to identify the key self-management skills needed to assert a more active role in their care</p> <p>A Transition CoachTM was introduced to help impart these skills and help the individual (and the family caregivers) become more confident in this new role</p> <p>The Intervention Focuses on Four Conceptual Domains Referred to as Pillars:</p> <ol style="list-style-type: none"> 1. Medication self-management 2. Use of a dynamic patient-centered record, the Personal Health Record 3. Timely primary care/specialty care follow up 4. Knowledge of red flags that indicate a worsening in their condition and how to respond <p>The Following Materials Are Available at No Cost:</p> <ul style="list-style-type: none"> -The business case for implementing the Care Transitions InterventionSM model • Training manual, video clips of the model in action, training DVD request form • Medication reconciliation tool, the Medication Discrepancy Tool (MDT)^{©TM} • NQF endorsed quality measure, the Care Transitions Measure (CTM) ^{©TM} <p>One hospital visit One home visit Series of calls</p>
<p>Project RED (Re-Engineered DC) http://www.bu.edu/fammed/projectred/index.html Brian Jack, MD</p>	<p>The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components</p> <p>The model consists of a discharge advocate using an After Hospital Care Plan</p> <p>The role of the <i>discharge advocate</i> consists of the following:</p> <ul style="list-style-type: none"> • Coordinating with medical team, RNs, and case managers • Educating patients about their disease • Educating patients about their medication • Arranging aftercare with patients & family • Reinforcing national quality guidelines • Arranging for medication pick-up, rides • Preparing and Reinforcing After Hospital Care Plan with patients & family <p>Patients are also called by a pharmacist 2-4 days post-discharge</p> <p>11 Key Components:</p> <ol style="list-style-type: none"> 1. Educate the patient about his or her diagnosis throughout the hospital stay.



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	2. Make appointments for clinician follow-up and post-discharge testing 3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results. 4. Organize post-discharge services. 5. Confirm the Medication Plan. 6. Reconcile the discharge plan with national guidelines and critical pathways. 7. Review the appropriate steps for what to do if a problem arises. 8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient’s care after discharge 9. Assess the degree of understanding by asking them to explain in their own words the details of the plan. 10. Give the patient a written discharge plan at the time of discharge 11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge Also developed ACP software and computer Avatar
Project BOOST (Better Outcomes for Older adults through Safe Transitions) http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm Mark Williams, MD, FHM	Essential Elements: <ol style="list-style-type: none"> 1. Institutional support 2. Multidisciplinary team or steering committee 3. Engagement of patients and families 4. Data collection and reliable metrics 5. Specific aims or goals 6. Standardized discharge pathways 7. Policies & Procedures 8. Comprehensive education Steps to take <ul style="list-style-type: none"> • Complete organizational assessment of current processes and identify opportunities for improvement • Implement interventions to improve transitions <ul style="list-style-type: none"> ○ TARGET <ul style="list-style-type: none"> ▪ 7Ps ○ Universal DC Checklist <ul style="list-style-type: none"> ▪ GAP ▪ Med Rec ▪ Med teach back ▪ Symptom teach back ▪ Action teach back ▪ DC education plan ▪ Communicate to next provider



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	<ul style="list-style-type: none"> ▪ Documentation of PCP receipt ▪ F/u with provider scheduled ○ Higher Risk Patients <ul style="list-style-type: none"> ▪ Face-to-face multidisciplinary rounds before dc ▪ Direct Communication with PCP before dc ▪ Call to pt within 48-96 hrs. ▪ Visit to PCP within 7 days ▪ Direct contact with care giver prior to 1st visit • Evaluate • Continue to improve
<p> Transitional Care Model http://www.transitionalcare.info Mary D. Naylor, PhD, RN, FAAN </p>	<p> Master's prepared advanced practice nurses Focus is on elderly patients who are at high risk for poor post-discharge outcomes These APNs are called Transition Nurse Managers Last approximately 8 weeks Includes comprehensive DC planning and home visits Key Components: <ul style="list-style-type: none"> • Focus on Patient and Caregiver Understanding • Helping Patients Manage Health Issues and Prevent Decline • Medication Reconciliation and Management • Transitional Care, Not Ongoing Case Management TCM includes ten essential elements: <ol style="list-style-type: none"> 1. The Transitional Care Nurse (TCN) as the primary coordinator of care to assure consistency of provider across the entire episode of care; 2. In-hospital assessment, preparation, and development of an evidenced-based plan of care; 3. Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge; 4. Continuity of medical care between hospital and primary care physicians facilitated by the TCN accompanying patients to first follow-up visits; 5. Comprehensive, holistic focus on each patient's needs including the reason for the primary hospitalization as well as other complicating or coexisting events; 6. Active engagement of patients and their family and informal caregivers including education and support; 7. Emphasis on early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to readmissions; 8. Multidisciplinary approach that includes the patient, family, informal and formal caregivers are part of a team; 9. Physician-nurse collaboration; and </p>



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	10. Communication to, between, and among the patient, family and informal caregivers, and health care providers and professionals.
<p>Transforming Care at the Bedside TCAB IHI & RWJ http://www.ihl.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/TCABHowToGuideTransitionHomeforHF.htm</p>	<p>1. Enhanced Admission Assessment for Post-Discharge Needs a. Include family caregivers and community providers (e.g., home health nurses, primary care physicians, HF clinic nurses, etc.) as full partners in standardized assessment, discharge planning, and predicting home-going needs. b. Reconcile medications upon admission. c. Initiate a standard plan of care based on the results of the assessment. 2. Enhanced Teaching and Learning a. Identify the learner(s) on admission (i.e., the patient and family caregivers). b. Redesign the patient education process to improve patient and family caregiver understanding of self-care. c. Use Teach Back daily in the hospital and during follow-up calls to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to do self-care. 3. Patient and Family-Centered Handoff Communication a. Reconcile medications for discharge. b. Provide customized, real-time critical information to the next care provider(s) that: (a) accompanies the patient to the next institution; and/or (b) is transmitted to the receiving physician and/or home health agency or other care providers at time of discharge. 4. Post-Acute Care Follow-Up a. High-risk patients: Prior to discharge, schedule a face-to-face follow-up visit (home care visit, care coordination visit, or physician office visit) to occur within 48 hours after discharge. b. Moderate risk patients: Prior to discharge, schedule a follow-up phone call within 48 hours and schedule a physician office visit within 5 days.</p>

Links to Other Resources: HealthNet Strength of Quality Conference

1. ARC: Avoiding Readmissions through Collaboration www.Calquality.org Search Readmissions
 - » On-site Meetings in Oakland plus teleconferences
 - » Julie France, (714) 735-8754, jfrance@pbgh.org
2. CHCF Report – “Homeward Bound: Nine Patient-Centered Programs Cut Readmissions”, Sept 2009. www.chcf.org/topics/chronicdisease/index.cfm?itemID=134064
3. Physician checklist for post-hospital visit www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist
4. State Report on Readmissions: www.oshpd.ca.gov/HID/Products/Health_Facts/index.html