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CENTERS FOR MEDICARE & MEDICAID SERVICES

Interventions to Improve Care Transitions and Reduce Readmissions

The following table contains information on select interventions that can help your organization reduce readmissions and improve the transitions process.

Intervention Strategy	Description	Tools	Enhanced admission assessment for discharge needs/ comprehensive discharge planning	Medication Management	Enhanced Teaching and Learning	Transition Care Processes	Care Coordination/ Communication	Chronic Care Management/ Self-Management
Acute Setting								
Project Re-Engineered Discharge (RED) www.bu.edu/fammed/projectred/index.html	Standardized discharge intervention in which a designated Discharge Advocate (DA) facilitates the care transition process by: • Coordinating the medical team • Providing patient education (disease and medication) • Improving care quality • Arranging after-hospital care plan with patients and family.	Project RED Discharge Advocate Training Manual • Patient education • Post-discharge clinician follow-up (testing, services, plan, etc.) • Medication plan • Emergency preparedness • Teach-back • Written discharge to patient • Telephone follow-up www.bu.edu/fammed/projectred/publications/FINALTrainingManual.pdf	✓	✓	✓	✓	✓	
Better Outcomes for Older adults through Safe Transitions (BOOST) www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm	Comprehensive implementation guide developed by the Society of Hospital Medicinethat provides resources to optimize the hospital discharge process and mitigate and prevent known complications and errors that occur during the transitions.	BOOST Implementation Guide to Improve Care Transitions • Screening/assessment tools • Discharge checklist / instructions • Transition record • Teach-back • Risk-specific interventions www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/Workbook_for_Improvement.pdf	✓	✓	✓	✓	✓	✓

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Transforming Care at the Bedside	Developed by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement to achieve four primary goals: 1. Safe and reliable care 2. Vitality and teamwork 3. Patient-centered care 4. Value-added care process Four core elements of the intervention: 1. Enhanced admission assessment for post discharge needs 2. Enhanced teaching/learning 3. Patient- and family-centered care practices 4. Early post-acute care follow-up	Tools for Transforming Care at the Bedside www.rwjf.org/files/research/3384.33055tcab.pdf			✓		✓	
		Transforming Care at the Bedside - Framework www.ihi.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/Framework.aspx			✓	✓	✓	✓
MULTIDISCIPLINARY SETTINGS								
Care Transitions Intervention® (CTI) (Coleman Model) www.caretransitions.org	4-week program facilitated by a Care Transitions coach in which patients with complex care needs receive tools (links provided to the right) and learn self-management skills to ensure needs are met during transition from hospital to	Personal health record www.caretransitions.org/documents/phr.pdf	✓				✓	✓
		Discharge preparation checklist www.caretransitions.org/documents/checklist.pdf	✓	✓	✓	✓	✓	✓
		Medication discrepancy tool www.caretransitions.org/documents/MDT.pdf		✓			✓	

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	home; focuses on four conceptual areas (or "pillars"): 1. Medication self-management 2. Dynamic, patient-centered recordkeeping 3. Follow-up 4. Red flags	Patient Activation Assessment tool www.caretransitions.org/documents/Activation_Assessment.pdf		✓			✓	✓
Transitional Care Model (TCM) www.transitionalcare.info	Provides comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults. Utilizes Transitional Care Nurse (TCN) as primary coordinator of care. TCM focuses on: 1. Patient-caregiver understanding 2. Helping patients manage health issues and prevent decline 3. Medication reconciliation and management 4. Transitional care, rather than ongoing case management.	The Transitional Care Model diagram www.transitionalcare.info/Abou-1783.html	✓			✓	✓	✓
		Key components of TCM: • Provider and clinician • Consumer and family member • Purchaser and policymaker www.transitionalcare.info/AbouAbou-1784.html		✓		✓	✓	✓
Bridge Model www.transitionalcare.org/the-bridge-model/	Social work-based approach to transitional care; fosters partnerships between hospitals and community-based organizations to aid transition of older adults back to the community. The model includes three phases: • Pre-discharge • Post-discharge • Follow-up	Bridge Model • Presentations • Overview www.transitionalcare.org/the-bridge-model/	✓	✓		✓	✓	

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Post-Acute Settings								
Geriatrics Resources for Assessment and Care of Elders (GRACE) http://medicine.iupui.edu/IUCAR/research/grace.aspx	Team-based care model that aims to improve the quality of geriatric care through continuity of care, smooth care transitions, and ongoing care management. These will be achieved through: • In-home geriatric assessments • Individualized care plans • Weekly interdisciplinary team conferences	Grace Interdisciplinary Team Suggestions Guide Each topic below has items to review with the PCP and routine intervention suggestions. Topics include: • Dementia • Depression • Difficulty walking and falls • Urinary incontinence • Malnutrition and weight loss • Chronic pain • Visual impairment • Hearing impairment • Medication management • Health maintenance • Advance care planning • Caregiver burdens http://medicine.iupui.edu/IUCAR/research/graceteamsuggestions.pdf	✓	✓		✓	✓	✓

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Interventions to Reduce Acute Care Transfers (INTERACT) www.interact2.net	Quality improvement program designed to improve the identification, evaluation, and communications about changes in resident status. Focuses on three areas of care: • Communication • Clinical care paths • Advance care planning	INTERACT II tools • Change in condition file card • Resident transfer form • Advance care planning • Stop and Watch early warning tool • Care paths • Acute care transfer checklist www.interact2.net/docs/INTERACT_II_Tool_Tablec.pdf			✓	✓	✓	
		SBAR Communication Tool www.interact2.net/docs/Communication%20Tools/SBAR%20updated%20February%202011.pdf					✓	
		Quality Improvement Tool www.interact2.net/docs/Quality%20Improvement%20Tools/Quality%20Improvement%20Tool%20updated%20Feb%202011.pdf				✓	✓	
Best Practices Intervention Packages www.homehealthquality.org/hh/default.aspx	Innovative resources to help providers prepare for health care changes; topics include reducing acute care hospitalizations, medication management, fall prevention, disease management, self care, and care coordination.	Best Practices Intervention Package III www.homehealthquality.org/shared/content/Campaign_Tracked_Files/cross3/Cross3BPIP_FINAL.pdf	✓	✓	✓	✓	✓	✓
		Best Practices Intervention Package II* www.homehealthquality.org/hh/default.aspx	✓	✓	✓	✓	✓	✓
		Best Practices Intervention Package I* www.homehealthquality.org/hh/default.aspx	✓	✓	✓	✓	✓	✓

*Registration required – register at www.homehealthquality.org/hh/campaign_registration/default.aspx.

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