

Evidence-based Care Transition Models • Page 1 of 2

	BOOST Better Outcomes for Older (adults through) Safe Transitions	Bridge	Care Transitions (CTI) “Coleman Model”	Transitional Care Model (TCM) “Naylor Model”	GRACE Geriatric Resources for Assessment and Care of Elders	Guided Care
TYPE	Hospital to Home Transition Model	Hospital to Home Transition Model	Hospital to Home Transition Model	Hospital to Home Transition Model	Practice-based coordination models with Care Transitions elements	Practice-based coordination models with Care Transition elements
AGE	<input type="checkbox"/> Age 18+, with focus on older adults.	<input type="checkbox"/> Age 60+	<input type="checkbox"/> Age 65+ (may apply to younger adults)	<input type="checkbox"/> Adults age 65+	<input type="checkbox"/> Age 65+	<input type="checkbox"/> Age 65+
RISK FACTORS	<input type="checkbox"/> If dementia is present, then a reliable caregiver is required.	<input type="checkbox"/> Two or more of the following: <input type="checkbox"/> Discharged with home health referral <input type="checkbox"/> Live alone <input type="checkbox"/> Hospitalized in the past six months <input type="checkbox"/> Caregivers stressed or overburdened <input type="checkbox"/> Determination of Need: 29+	<input type="checkbox"/> Should be community dwelling adults with a working telephone. <input type="checkbox"/> Have at least one of 11 diagnoses. <input type="checkbox"/> Appropriate for persons with depression or dementia, provided they have willing and able family caregivers.	<input type="checkbox"/> Two or more risk factors, including: <input type="checkbox"/> Poor self health ratings <input type="checkbox"/> Multiple chronic conditions <input type="checkbox"/> History of recent hospitalizations <input type="checkbox"/> Cognitively intact (current testing among cognitively impaired hospitalized older adults and long-term care recipients).	<input type="checkbox"/> Low-income <input type="checkbox"/> May include adults at high risk of hospitalization (probability of repeated risk admission screen).	<input type="checkbox"/> Persons with medically complex health conditions. <input type="checkbox"/> At high risk of using health services heavily during the following year, as estimated by the claims-based Hierarchical Condition Category (HCC) predictive model.
POINT OF ENTRY	<input type="checkbox"/> Loose structure	<input type="checkbox"/> Hospital (with integrated Aging Resource Center)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital (at admission)	<input type="checkbox"/> Primary care physicians' office	<input type="checkbox"/> Primary care physicians' office
GOALS	<input type="checkbox"/> Improve the care of patients as they transition from the hospital to home. <input type="checkbox"/> Provide resources to optimize the hospital discharge process. <input type="checkbox"/> Reduce 30-day hospital readmission rate. <input type="checkbox"/> Promote patient empowerment. <input type="checkbox"/> Improve information flow between hospital and outpatient physicians. <input type="checkbox"/> Improve patient satisfaction. <input type="checkbox"/> Ensure high-risk patients are offered specific interventions to reduce risk. <input type="checkbox"/> Improve patient and family education practices to encourage use of the teach-back process around risk specific issues.	<input type="checkbox"/> Reduce caregiver stress. <input type="checkbox"/> Increase consumer safety. <input type="checkbox"/> Reduce ED visits. <input type="checkbox"/> Reduce re-hospitalizations. <input type="checkbox"/> Improve adherence to the medical plan of care. <input type="checkbox"/> Increase older adult and caregiver satisfaction.	<input type="checkbox"/> Reduce rates of rehospitalization. <input type="checkbox"/> Increase patient confidence during transition and beyond. <input type="checkbox"/> Empower the patient and caregiver to assert a more active role during care transitions. <input type="checkbox"/> Develop lasting self-management skills. <input type="checkbox"/> Use a patient-centered health record to guide patients through the care process. <input type="checkbox"/> Coordinate primary care provider and specialist follow-up. <input type="checkbox"/> Promote patient understanding of “red flags” and appropriate next steps.	<input type="checkbox"/> Reduce rates of rehospitalization. <input type="checkbox"/> Reduce ED visits for primary and co-existing conditions. <input type="checkbox"/> Prepare patients and caregivers to more effectively manage changes in health associated with multiple chronic illnesses. <input type="checkbox"/> Reconcile and manage medications. <input type="checkbox"/> Improve health outcomes after discharge. <input type="checkbox"/> Enhance patient and family caregiver satisfaction. <input type="checkbox"/> Reduce total (i.e., physician, hospital, and home health) health care costs.	<input type="checkbox"/> Improve quality of care. <input type="checkbox"/> Reduce acute care utilization among a high-risk group.	<input type="checkbox"/> Provide intensive transitional care. <input type="checkbox"/> Uses motivational interviewing to promote self-management. <input type="checkbox"/> Provide continuing education, resources, and support for family caregivers. <input type="checkbox"/> Address complex chronic conditions. <input type="checkbox"/> Employ a rigorous curriculum to ensure that RNs possess necessary skills. <input type="checkbox"/> Utilize Electronic Health Record.
STAFFING	<input type="checkbox"/> No explicit care coordinator. <input type="checkbox"/> Team orientation, including clinical nursing staff, MDs, primary care physician, Social Workers, case managers, pharmacists, medical records personnel, hospital informatics, data analyst, nutrition/dietary staff. <input type="checkbox"/> Family caregivers <input type="checkbox"/> Optional: ED staff	<input type="checkbox"/> Social Workers	<input type="checkbox"/> Nurse/Transition Coach (model is open to person not being a nurse). <input type="checkbox"/> Someone with strong interpersonal skills, the ability to make the shift from doing things for patients to facilitating skill transfer so that the patients can do more for themselves	<input type="checkbox"/> Transitional Care Nurse (In the study, this was an advanced practice nurse with a MSN degree and advanced knowledge and skills in serving older adults. Currently evaluating outcomes with bachelors-prepared nurse.)	<input type="checkbox"/> Program utilizes nurse practitioner and social worker who work with the primary care physician, geriatrician, and other relevant health professional in a team-based approach	<input type="checkbox"/> Must be a registered nurse, ideally with experience in home care, case management, community health and/or equivalent gerontologic nursing
LENGTH OF INTERVENTION	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> On call seven-days per week <input type="checkbox"/> Home visits and telephone access for one to three months of home follow-up (two months on average)	<input type="checkbox"/> Long term/indefinite. <input type="checkbox"/> Contact with patient in evaluation was two years.	<input type="checkbox"/> Long term/usually for life.

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DESCRIPTION	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Use team approach to assess patients' risk for re-hospitalization. <input type="checkbox"/> Plan and execute risk-specific discharge planning activities. <input type="checkbox"/> Tailor communications. <input type="checkbox"/> Provide outpatient providers and receiving sites with a discharge record. <p>Post-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Use "teach back" for discharge education: <ul style="list-style-type: none"> o Simple lay language, with explanation and/or demonstration. o Asks patient/caregiver to repeat in his or her own words. o Identifies/corrects misunderstandings o Repeats steps until convinced that patient/caregiver comprehends information and safely is ensured. <p>Follow-up (for high-risk patients)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Outpatient follow-up visit is scheduled, and/or <input type="checkbox"/> A 72 hour follow-up call with the patient and/or the caregiver is conducted. 	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identify patients for participation (at Rush University Medical Center, hospitalized clients are identified through a risk screen integrated into the Electronic Health Record). <input type="checkbox"/> Meet with patient and/or caregiver in hospital room or in the hospital's Aging Resource Center. <input type="checkbox"/> Identify unmet needs. <input type="checkbox"/> Set up services prior to discharge. <input type="checkbox"/> Provide discharge information (i.e., a patient-friendly, one-page "Patient PASS" containing all vital information for successful transition (e.g., test results, diagnoses, MD contact info, warning signs, follow-up appointments, medication regimen) <p>Post-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Call participant within 48 hours of discharge to assess their situation. <input type="checkbox"/> Make additional calls or schedule face-to-face visits to resolve identified problems. <input type="checkbox"/> Utilize consumer-driven health record to relay critical information to care providers involved with an older adult's post-discharge care <p>Follow-up</p> <ul style="list-style-type: none"> <input type="checkbox"/> At 30 days post-discharge, track patient's progress and address emerging needs. 	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Transition coach conducts hospital visit <input type="checkbox"/> Uses tools such as the Personal Health Record (PHR) <p>Post-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conducts one home visit 24-72 hours post discharge <input type="checkbox"/> Actively engages patients in medication reconciliation. <input type="checkbox"/> Uses role-playing and other tools to transfer skills. <input type="checkbox"/> Reviews any "red flags" that indicate a worsening of conditions and strategies for how to respond to these red flags should they manifest. <p>Follow-up</p> <ul style="list-style-type: none"> <input type="checkbox"/> Performs three follow-up phone calls reinforcing coaching <input type="checkbox"/> Discusses encounters with health care professionals <input type="checkbox"/> Reinforces importance of maintaining/sharing the PHR & supports patient's self-management role. 	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assessment in hospital room (including details of patient's functional status). <input type="checkbox"/> Daily visits. <input type="checkbox"/> Collaborate with care team members to reduce adverse events and prevent functional decline. <input type="checkbox"/> Develop a streamlined evidenced-based plan of care. <p>Home visit (within 24 hours of discharge):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Evaluate ADLs/IADLs/safety. <input type="checkbox"/> Recommend adaptations. <input type="checkbox"/> Refer to other services. <p>Follow-up:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Accompany patient to post-discharge MD visit and subsequent visits, as needed <input type="checkbox"/> Facilitate MD-RN collaboration across episodes of acute care <input type="checkbox"/> Conduct weekly home visits for one month. <input type="checkbox"/> Make phone contact for each week if in-person visit not scheduled. <input type="checkbox"/> On-call seven days per week for home visits and telephone access.. <input type="checkbox"/> Provide active engagement of patients and family caregivers with focus on meeting their goals. <input type="checkbox"/> Facilitate communication among patient, family caregivers, and health care professionals. 	<p>Nurse or Social Worker</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conducts home visit <input type="checkbox"/> Meets with GRACE interdisciplinary team <input type="checkbox"/> Meets with primary care physician <input type="checkbox"/> Implements individualized care plan <input type="checkbox"/> Arranges additional home visits and phone calls, as necessary. <input type="checkbox"/> Supports transition from hospital to home 	<p>Guided Care Nurse:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conducts in-home assessment <input type="checkbox"/> Creates a care guide and an action plan for patients <input type="checkbox"/> Provides monthly monitoring and self-management coaching <input type="checkbox"/> Provides smooth transitions into/out of hospitals and other institutions <input type="checkbox"/> Coordinates care by all providers <input type="checkbox"/> Provides family caregiver education/support <input type="checkbox"/> Facilitates access to community based services.
STAFF TRAINING	<ul style="list-style-type: none"> <input type="checkbox"/> Day long training sessions (fee-based) <input type="checkbox"/> Year-long coaching/mentoring program (free, courtesy of grant from the John A. Hartford Foundation). 	<ul style="list-style-type: none"> <input type="checkbox"/> Bridge Training Module 	<ul style="list-style-type: none"> <input type="checkbox"/> Recognition as an official CTI adoption, and model fidelity, requires one-day training for the Transition Coach, delivered by CTI staff on-site or in Aurora (Denver), CO. 	<ul style="list-style-type: none"> <input type="checkbox"/> U of Penn Web-based training modules prepare nurses to become Transitional Care Nurses, plus training on the clinical information system. It takes on average of one month to orient a new TCN. 	<ul style="list-style-type: none"> <input type="checkbox"/> Nurse Practitioners and Social Workers complete a 12-session training program (with meetings held once a week) on GRACE protocols and interdisciplinary teamwork). 	<ul style="list-style-type: none"> <input type="checkbox"/> All candidates must complete the Johns Hopkins 6-week, 40 hour web-based course, pass on on-line exam, and earn a Certificate in Guided Care Nursing from the ANCC.
COST	<ul style="list-style-type: none"> <input type="checkbox"/> Unknown, but includes tuition (\$28,000 per site). 	<ul style="list-style-type: none"> Unknown 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention cost was \$74,310 (\$196 per patient) 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention cost was \$115,856 (\$982 per patient) 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention costs for high risk patients: \$315,040 (\$1,432 per patient) 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention cost was \$95,900 (\$1,743 per patient)
WEB	www.hospitalmedicine.org/BOOST	http://hmpgrg.org/programs-projects/illinois-transitional-care-consortium/	www.caretransitions.org	www.transitionalcare.info	http://medicine.iupui.edu/IUCAR/research/grace.asp	www.guidedcare.org