Strengthening Care Transitions

For Improved Facility Dashboards and Patient Outcomes

Presented by:

Heather Meadows, CCC/SLP
Executive Director of PA, Certified Dementia Practitioner (CDP)
Premier Therapy

Objectives:

1. Participant will define care transitions and how to include the patient as a partner and driver of the care plan for the transition process
2. Participant will list at least three tools available to improve information flow via electronic and traditional means
3. Participant will describe a transitional care program and its components for successful hand offs
4. Participant will list IDT members and roles needed to implement and execute a successful transition
5. Participant will describe strategies and systems necessary for the IDT members to improve outcomes and facilities benchmarks

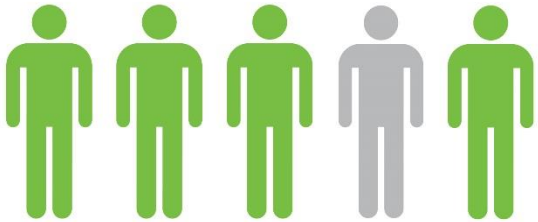
Definition: Transitional Care

- The movement of patients between healthcare practitioners and settings depending on their condition and their care needed during their course of illness www.caretransitions.org

- The actions taken by the IDT members are to ensure coordinated and continuum of care. As part of a comprehensive care plan, the health care team will report patient's goals, preferences, and status to next provider. This information is given for proactive planning in the next environment and may include education to patient and family and adaptive equipment, and program recommendations www.ntocc.org

Why Care Transition?

- Nearly 1 in 5 Medicare patients discharged from a hospital—approximately 2.6 million seniors is readmitted within 30 days, at a cost of more than $26 billion every year (CMS, 2016).



- Inadequate care transitions (CT) planning, communication failures, and delays in scheduling post-hospitalization care are among the most common causes of preventable readmissions (Bisognano & Boutwell, 2009).

https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf

Why Care Transitions?

- To help address these issues, the Centers for Medicare & Medicaid Services (CMS) launched the Partnership for Patients in 2011, with the initial goal of reducing hospital-acquired conditions by 40% and readmissions by 20%
- One way that the Partnership for Patients attempted to decrease readmissions was through the Community-based Care Transitions Program (CCTP)
- Mandated by Section 3026 of the Affordable Care Act, the CCTP provided a framework for community-based organizations (CBOs) to partner with hospitals to address the needs of high-risk Medicare Fee-For-Service (FFS) beneficiaries
- It helps improve overall care and path to healing for patient
- Hospital penalties occurring with readmissions as an outlier
- SNF penalties- Recent reports posted in August 2018 of impending penalties in reimbursement

https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf

Risk Factors for Re-admission

- Lack of follow-up appointments or delays scheduling post-hospitalization care (Felix, Seaberg, Bursac, Thostenson, & Stewart, 2015)

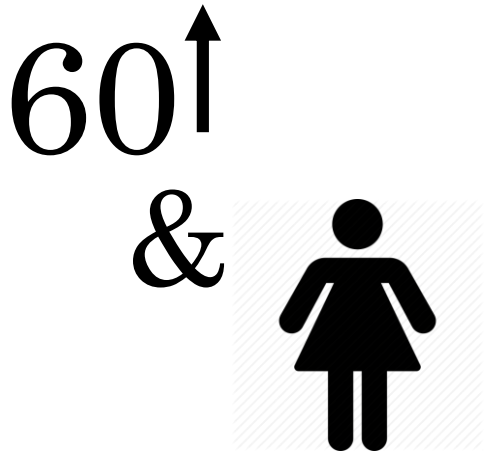
- Inability to keep follow-up appointments, lack of awareness of whom to contact after discharge, and communication failure between inpatient and outpatient providers (Auerbach, Kripalani, & Vasilevskis, 2016)

- Lack of collaboration of HealthCare entities and practitioners for carry over with patient

STUDY: Readmissions

- Study conducted from June 2006 to May 2008 at Medical Center in San Francisco California on general medicine patients with diagnoses of cancer, pneumonia, COPD and cardiac issues.
- They examined all readmissions and excluded deaths and planned readmissions
- They found within that 2 year period 10,359 admissions occurred with 17% being readmitted within 30 days (1,761 patients)

Of those readmitted: Most were 60 years or older, female (52.8%), LOS was 5.6 days, Medicare patients were 50% of re-admissions, 90% of readmits had a high risk medication and almost 80% came from home (only 9% from SNF)



STUDY: Readmissions

- A visit to Emergency Department
  - (85% of readmits were referrals from ED)
- 44.6% were Caucasian
- African American and Medicaid recipient
- 17% of readmits had primary language other than English
- 21% of readmits were discharged on weekend
- 95% of readmits had at least one high risk medication:
  - Narcotic
  - Steroids
  - or cardiovascular med
- Comorbidities: such as CHF, renal disease, cancer, anemia and depression, weight loss, psychiatric disease and hypertension

To Reduce Risk of Readmission

- Must identify patient population most at risk
- Reduce risk within that population through education, patient engagement, pre-discharge activities, mobility interventions with therapy, collaboration and access to better home and community services and post discharge communication and services
- Education and training to manage medications and warning signs with goal to avoid polypharmacy

To Reduce Risk of Readmission

- Address access and affordability of medications- involve pharmacist
- Engage patients, caregivers and IDT throughout process
- Analyze outcomes and implement plans to reduce risk for your facility
- Work with local hospitals and hospitalists

Malnutrition Can Be a Problem

33% at risk in community and over 80% in facility settings

Causes may be:

- Social isolation and lack of desire
- Limited transportation and access to healthy foods
- Financial constraints
- Decreased ability to prepare food with both regular and specialty diets

Have a plan and ensure abilities PRIOR to discharge to another setting. Make sure health team downstream is aware.

Be Aware If Resident…

- Expresses concern about going to new setting
- Is uncomfortable with discharge and plans
- Expresses safety concerns

Be Aware of Signs of Delirium with Transitions

- Usually rapid onset of distraction and inattention
- Disorganized thinking

To help reduce risk of delirium:

- Make environment familiar as able
- Address any sensory deficits that can help increase confusion: *i.e. hearing aids, glasses etc.*
- Maintain routines as much as possible
- Keep patient hydrated and nutritionally sound
- Look for signs of pain

Risk Identification Key for IDT

- It is important to identify risks and put preventative measures in place for a successful transition of care

- Two tools that can help identify risks are:
  - **LACE model** – Length of stay, Acuity of admission, Co-morbidities and Emergency Department use
  - **8 P's Risk Assessment Tool-** Addresses both clinical and psychosocial variables

LACE Index Scoring Tool for Risk Assessment of Hospital Readmission

Step 1. **Length of Stay**

Length of stay (including day of admission and discharge): _____ days

Length of Stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7

L

Step 2. **Acuity of Admission**

Was the patient admitted to hospital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

A

Step 3. **Comorbidities**

Condition	Score (circle as appropriate)
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes without complications	+1
Congestive heart failure	+2
Diabetes with end organ damage	+2
Chronic pulmonary disease	+2
Any tumor (including lymphoma or leukemia)	+2
Dementia	+3
Connective tissue disease	+3
AIDS	+4
Moderate or severe liver or renal disease	+4
Metastatic solid tumor	+6
TOTAL	

If the **TOTAL** score is between 0 and 3, enter the score into Box C. If the score is 4 or higher, enter 5 into Box C.

C

Step 4. **Emergency Department Visits**

How many times has the patient visited an emergency department in the 6 months prior to admission (not including the emergency department visit immediately preceding the current admission)?

_____

Enter this number or 4 (whichever is smaller) in Box E

E

Add numbers in Box L, Box A, Box C, and Box E to generate Lace score and enter number into box below

LACE

LACE score risk of readmission: ≥ 10 High Risk

The 8 P's:

Assessing Your Patient's Risk for Adverse Events After Discharge

- Problem Medications
- Psychological
- Principal Diagnosis
- Polypharmacy
- Poor Health Literacy
- Patient Support
- Prior Hospitalization
- Palliative Care

Risk Assessment: 8P Screening Tool (Check all that apply.)	**Risk Specific Intervention**
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, highlighting this issue if new ☐ Involvement/awareness of support network insured
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications
Patient support (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available

FRAIL Test

F	**Fatigue**	Do you tire easily?
R	**Resistance**	Can you climb 1 flight of stairs?
A	**Ambulation**	Can you walk 1 block?
I	**Illness**	Do you have more than 5 chronic illnesses?
L	**Loss of Weight**	Have you lost more than 5% body weight?

If patients answer yes to 3 or more questions:
Increased risk for falls and fractures, disability, complications and death. More risk of re-admission.

Root Causes of Ineffective Transitions of Care

Breakdowns with:

Communication	Education	Accountability
Different expectations patient to caregiver	Not completed	No leader to drive program and implement plans
Not timely	Received contradictory information	No risk assessment that leads to poor planning
Culture doesn't promote teamwork	Confusion with regimes	Lack of knowledge or resources to be effective
Not enough time to do what is needed	Not good patient buy in	
Lack of standardized procedures	Lack of understanding with diagnosis, care plan or medication routines	

Turn Breakdowns Around

Keys for Success

- Early risk identification through tests
- Individualized plan of care
- Early involvement and training by IDT members to patients and caregivers
- Early home assessment with caregiver training and return demonstration
- Plan A, B or C established in care plan within 24-48 hours
- Designated care manager

7 Interventions Necessary for Smooth Transition

- According to the National Transition of Care Coalition there are **3 patient and caregiver** interventions and **4 provider** interventions necessary for a smooth transition

NATIONAL TRANSITIONS OF CARE COALITION

Patient and Caregiver Interventions

- Medication management
- Transition care planning
- Patient and caregiver engagement and education

Provider Interventions

- Information transfer
- Follow up care
- Healthcare provider engagement
- Shared accountability across organizations (upstream and downstream)

Medication Management

- Assess patient's intake and education/plan
  - Compare current plan of meds to plan when admitted
  - Is the plan realistic and simple?
  - Do you foresee any risks with plan when at home?
  - Is there a need for new education with new med or new caregiver?
  - Are the roles clear for playmakers during transition and at new setting?
  - Is there a plan for follow up post discharge?
  - Is there a written follow up plan and is it clear to patient and caregivers?
  - Has the patient or caregiver(s) explained/demonstrated how they will manage the medications?

Components of a Transitional Care Program

- Patient and caregiver engagement/education Day 1
- Individualized POC
- Point person for transition
- IDT involvement
- Hospital visit pre-discharge
- Home/setting visits post-discharge/ Home Health or Outpatient Therapy
- Physician involvement and visits/pre-arrange appointments
- Phone support/Telehealth

Components of Program

- Early completion of home/discharge setting assessment is an important component for further needs and education necessary for a successful transition
- Witnessing return demonstration and documenting results are vital
- Skipping this step can lead to adverse outcomes

Components of a Transitional Care Programs

- Medication management
- Access to community resources/ transportation/meals/housekeeping
- Contact numbers for support
- Health promotion and disease/risk prevention
- Health monitoring devices
- Engagement in community
- Counseling in benefits and insurance

Interdisciplinary Team & Roles

- **Admission Nurse/Case Manager**
  - Liaison for hospital
  - Coordinates stay in SNF and hand off from hospital or other setting
- **Nursing/MDS**
  - Coordinates care during stay in SNF/documents services
  - MDS reflects services rendered
- **Therapy**
  - Provides individualized plan of care
  - Coordinates/educates with IDT and downstream caregivers/family
- **Social Worker**
  - Liaison for resident while in SNF
  - Coordinates home-going discharge plans including appointments, services and equipment
  - Collaborates with IDT members

Interdisciplinary Team & Roles

- **Physician**
  - Oversees medical and clinical services while prescribing treatment and medicines as necessary
  - Works with patients and families for best path to recovery and independence
- **Pharmacist**
  - Coordinates with nursing and physician for medication management and smooth transition to downstream setting
  - Must provide follow-up services/calls to keep patient safe and as independent as possible
- **DME Rep**
  - Coordinates with facility for proper equipment and timely placement

Best Practice for Care Transitions

- Must have comprehensive discharge planning
  - Including addressing patient's financial and psychosocial issues that may put patient at risk for receiving care or community services needed
  - Follow-up calls from appropriate healthcare professionals to address medications, new symptoms, questions, and provide further education or guidance for success in their new environment
  - Must have full information prior to patient being admitted to facility and SNF team must send information prior to patient going to next downstream environment
  - Involve downstream caregivers or family members in care Day 1 and have them part of therapy sessions and meetings ongoing

Best Practice for Care Transitions

- Timely, complete and accurate communication of information
  - Preferably written or through interface of software
  - Include diagnoses, tests, procedures, medication list, advanced directives, caregiver instructions, contact information for vital healthcare professionals and any appointments or follow up care scheduled or needed
  - Make sure clinical staff is highly skilled in clientele from hospital and can treat them effectively
  - Make sure staffing is able to handle workload and diagnoses
  - Everyone know their role and hold each other accountable for success

Best Practice for Care Transitions

- Medication Management/Reconciliation
  - Check accuracy of medication list and dosages
  - Look for contraindications
  - Assess financial barriers to filling prescriptions
  - Send final instructions and medications to downstream caregivers
  - Involve physician or pharmacist as needed
  - Educate frontline staff on vital sign changes and adverse effects and how to recognize them

Best Practice for Care Transitions

- Teach and ask for return demonstration of concepts and routine by both patient and caregivers
- Give written instructions to patient and caregivers
- Teach patients and caregivers warning signs
- Teach them what to do if an issue arises- also give them the option of calling SNF or coming back to SNF if needed to avoid a hospital/Emergency Room admission if appropriate
- Timely responses to hospital, SNF IDT and downstream caregivers, as well as, patients so communication is open and keeps process moving

Best Practice for Care Transitions

- Be mindful of when and time discharging patients to another setting-avoid weekends and late or early times during the day
- You want to make sure services needed by patient are available to evaluate and provide services or make sure equipment is present for their discharge to decrease risk of problems for patient
- Program should involve follow up visits and/or calls within 24 hrs, 7 days, 14 days, 30 days, 45 days and 60 days by facility designee and document it being done and the results
- Finally it is important to track outcomes, patient/caregiver satisfaction, and effectiveness of program so improvements, if needed, can be addressed timely

Best Practice for Care Transitions

- Tele-monitoring/Telehealth- newer concept, not reimbursable everywhere yet and is mainly limited to physicians –but could be avenue in future for all
- It can allow long distance monitoring of the patient's blood pressure and glucose levels to prevent further issues

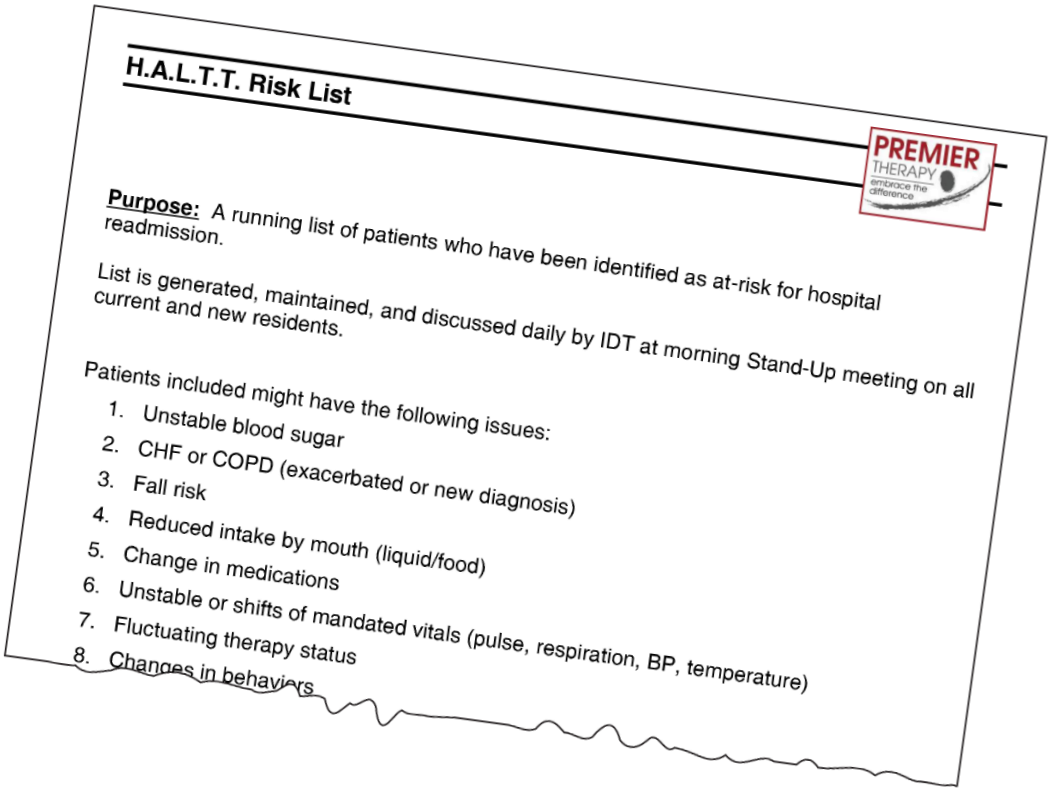
Quality Program

Must be able to deliver **quality services** with great **outcomes** at a **reduced cost** that effectively **meets the patients' needs** so minimal issues arise and readmissions to the hospital are rare

What does your program look like?

Quality of Care- Early Risk Identification

- Decrease hospital re-admission rates
  - H.A.L.T.T. Program



H.A.L.T.T. Risk List

PREMIER THERAPY embrace the difference

Purpose: A running list of patients who have been identified as at-risk for hospital readmission.

List is generated, maintained, and discussed daily by IDT at morning Stand-Up meeting on all current and new residents.

Patients included might have the following issues:

1. Unstable blood sugar
2. CHF or COPD (exacerbated or new diagnosis)
3. Fall risk
4. Reduced intake by mouth (liquid/food)
5. Change in medications
6. Unstable or shifts of mandated vitals (pulse, respiration, BP, temperature)
7. Fluctuating therapy status
8. Changes in behaviors

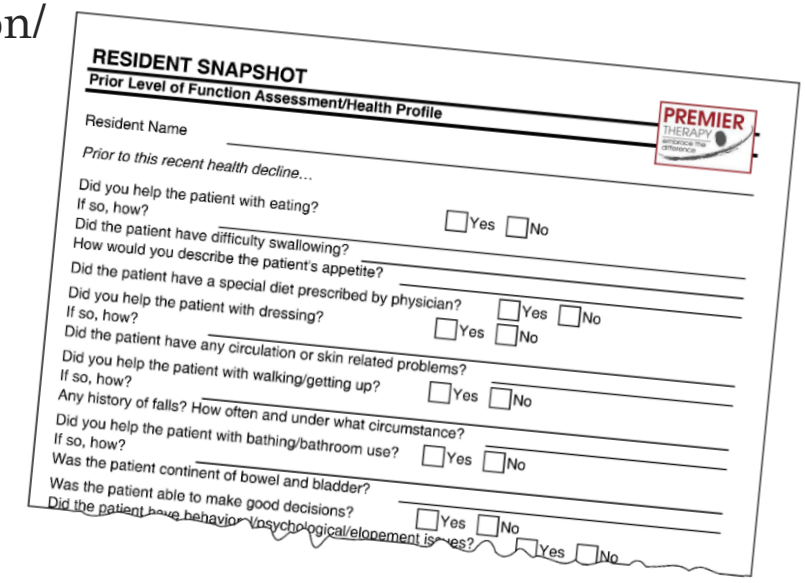
Quality of Care: *Therapy Active IDT Member*

- Proactive Rehab Department
  - Eval and treat Day 1
  - Develop individualized plan of care
  - Provide up-to-date functional documentation
  - 7 days/week therapy
  - Involve nursing in therapy goals Day 1 to increase carryover

Communication

This is key!

- Hospital wants to align themselves with the best providers in their market
- How can you be the best?
  1. **Preadmission planning**
     - Utilize a tool to collect PLOF information from resident and/or family
     - Plan for individualized equipment needs
     - Collect acute care information/ history from hospital Case Manager or Hospital liaison


RESIDENT SNAPSHOT

Prior Level of Function Assessment/Health Profile

PREMIER THERAPY

Resident Name

Prior to this recent health decline...

Did you help the patient with eating? ☐Yes ☐No
If so, how?
Did the patient have difficulty swallowing?
How would you describe the patient's appetite?
Did the patient have a special diet prescribed by physician? ☐Yes ☐No
Did you help the patient with dressing? ☐Yes ☐No
If so, how?
Did the patient have any circulation or skin related problems?
Did you help the patient with walking/getting up? ☐Yes ☐No
If so, how?
Any history of falls? How often and under what circumstance?
Did you help the patient with bathing/bathroom use? ☐Yes ☐No
If so, how?
Was the patient continent of bowel and bladder?
Was the patient able to make good decisions? ☐Yes ☐No
Did the patient have behavior/psychological/elopement issues? ☐Yes ☐No

Communication

This is key!

2. **Morning Huddle**
   - Whiteboard
   - Active tracking and planning
   - Daily review of status goals and d/c planning
   - Involve all of IDT as necessary
   - Everyone must bring something to table

3. Family Communication
   - Schedule family meeting within 24 hours
   - Discuss realistic d/c plans
   - Develop a d/c Plan A and Plan B
   - Encourage family participation in therapy
   - Develop trust

Communication

This is key!

4. Nursing Communication

- Educate on resident status and goals for increased carryover
- Provide therapy on units and involve nursing staff

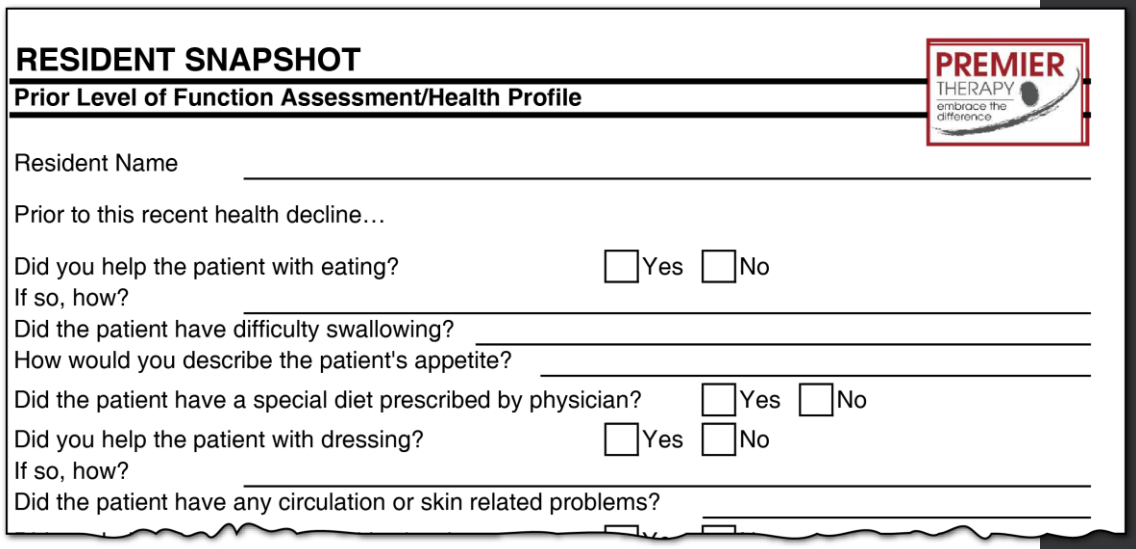
5. QUEST Program

- Sample of Therapy program that streamlines data and provides a detailed flowsheet of what needs to happen next

Process Flow for Premier Therapy
QUEST Program

Resident Snapshot

- Identify Risk Areas
- Capture D/C plans on admission



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Did the patient have a special diet prescribed by physician? ☐ Yes ☐ No

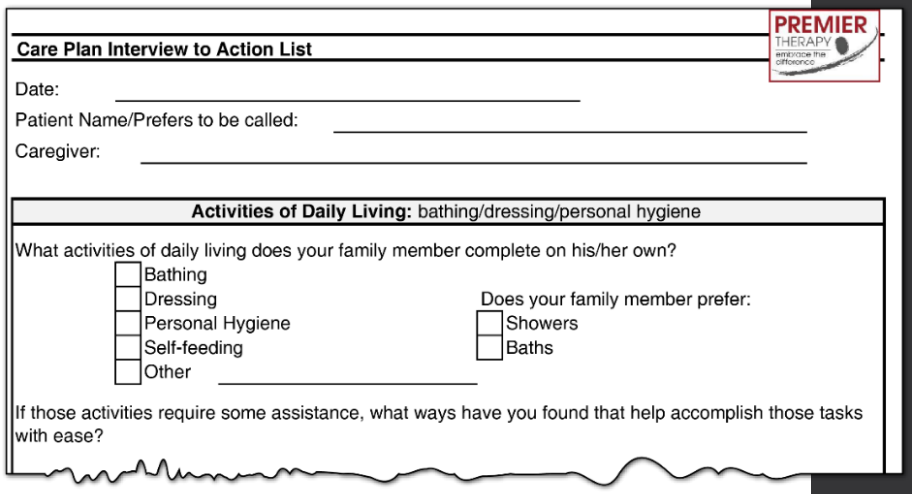
Did you help the patient with dressing? ☐ Yes ☐ No

If so, how? _____

Did the patient have any circulation or skin related problems? _____

Process Flow for QUEST Program *(continued)*

- Care Plan Meeting within 24 hours (or by facility policy)
- Utilize ***Interview to Action List***
- Clarify Discharge Plans
- Implement IDT Assignments, Comprehensive Assessments, and ***Pause: What is the Root Cause?***



PREMIER THERAPY embrace the difference

Care Plan Interview to Action List

Date: _____

Patient Name/Prefers to be called: _____

Caregiver: _____

Activities of Daily Living: bathing/dressing/personal hygiene

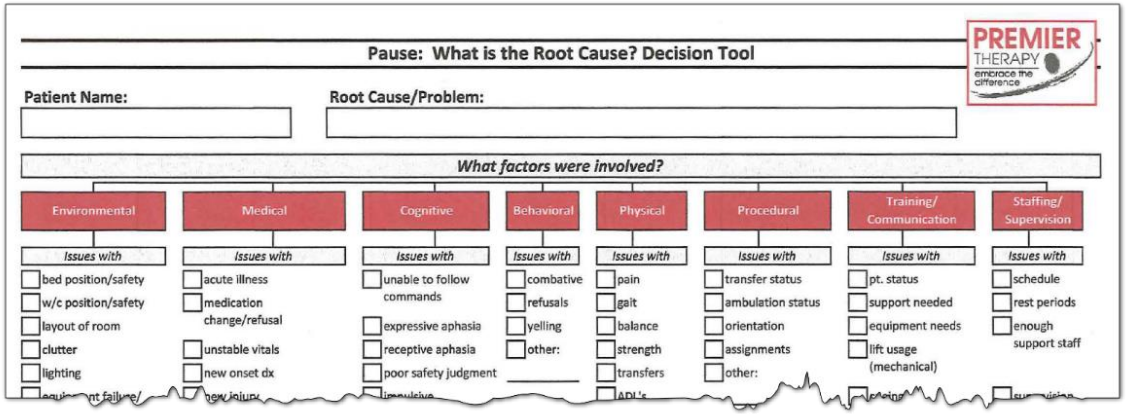
What activities of daily living does your family member complete on his/her own?

- ☐ Bathing
- ☐ Dressing
- ☐ Personal Hygiene
- ☐ Self-feeding
- ☐ Other _____

Does your family member prefer:

- ☐ Showers
- ☐ Baths

If those activities require some assistance, what ways have you found that help accomplish those tasks with ease?



PREMIER THERAPY embrace the difference

Pause: What is the Root Cause? Decision Tool

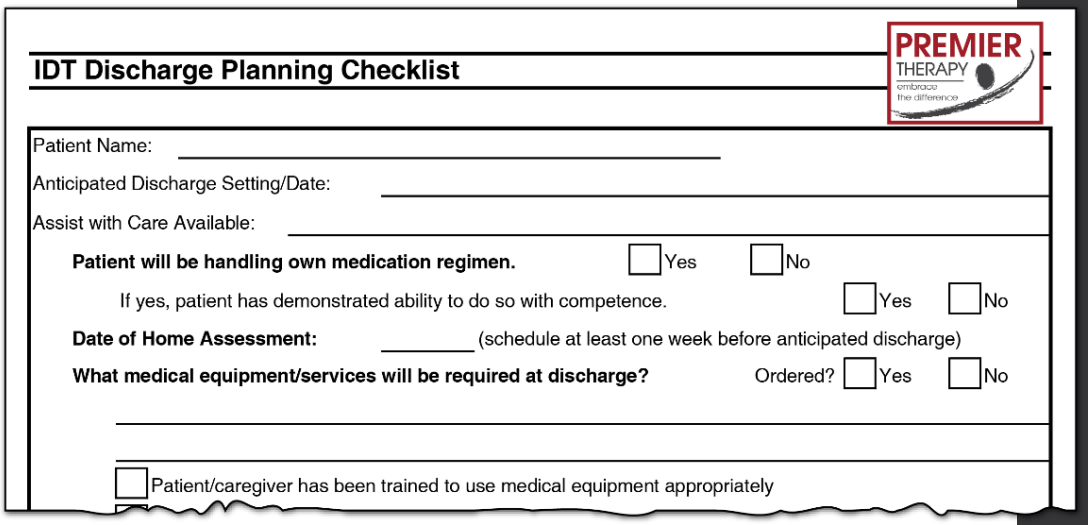
Patient Name: _____ **Root Cause/Problem:** _____

What factors were involved?

Environmental	Medical	Cognitive	Behavioral	Physical	Procedural	Training/ Communication	Staffing/ Supervision
Issues with	*Issues with*	*Issues with*	*Issues with*	*Issues with*	*Issues with*	*Issues with*	*Issues with*
☐ bed position/safety	☐ acute illness	☐ unable to follow commands	☐ combative	☐ pain	☐ transfer status	☐ pt. status	☐ schedule
☐ w/c position/safety	☐ medication change/refusal	☐ expressive aphasia	☐ refusals	☐ gait	☐ ambulation status	☐ support needed	☐ rest periods
☐ layout of room	☐ unstable vitals	☐ receptive aphasia	☐ yelling	☐ balance	☐ orientation	☐ equipment needs	☐ enough support staff
☐ clutter	☐ new onset dx	☐ poor safety judgment	☐ other: _____	☐ strength	☐ assignments	☐ lift usage (mechanical)	
☐ lighting	☐ new injury	☐ impulsive		☐ transfers	☐ other:	☐ cueing	☐ supervision
☐ equipment failure/				☐ ADL's			

Process Flow for QUEST Program *(continued)*

- Review Plan in Morning meeting
- Initiate ***IDT Discharge Planning Checklist***
- Review goals and discharge needs
- Caregiver Education & Training
- Invite D/C practitioners into facility and work with them directly



IDT Discharge Planning Checklist

PREMIER THERAPY embrace the difference

Patient Name: _____

Anticipated Discharge Setting/Date: _____

Assist with Care Available: _____

Patient will be handling own medication regimen. ☐ Yes ☐ No

If yes, patient has demonstrated ability to do so with competence. ☐ Yes ☐ No

Date of Home Assessment: _____ (schedule at least one week before anticipated discharge)

What medical equipment/services will be required at discharge? Ordered? ☐ Yes ☐ No

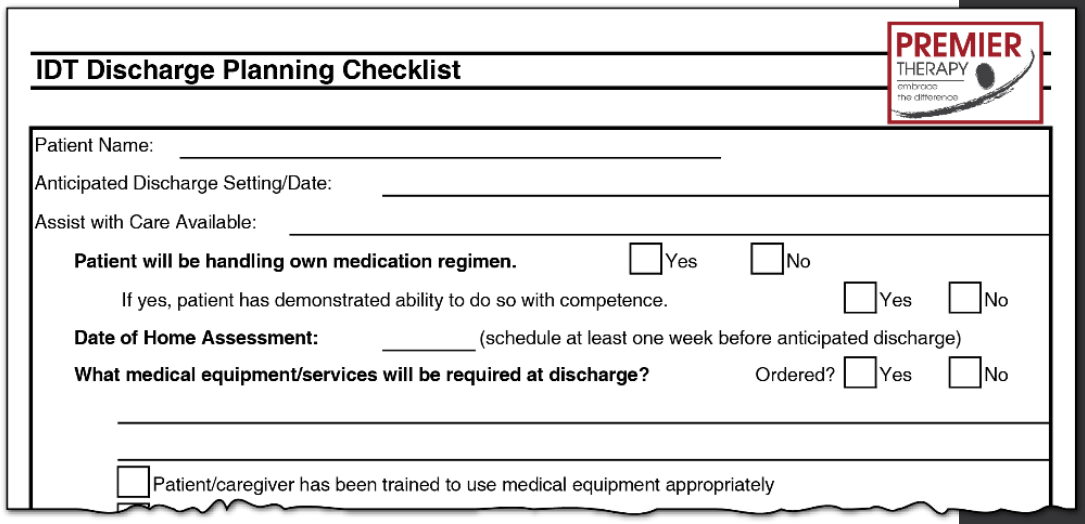
_____

_____

☐ Patient/caregiver has been trained to use medical equipment appropriately

Process Flow for QUEST Program *(continued)*

- Prior to Discharge:
  - Written instructions for recommendation on equipment/services needed
  - All aspects of care trained and understood by caregivers
  - Complete ***D/C Planning Checklist***



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_____

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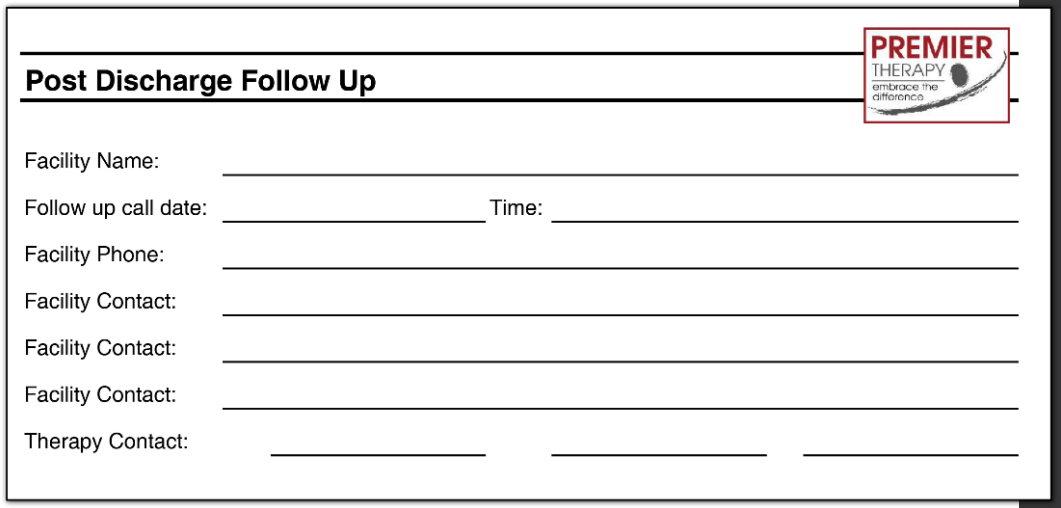
Process Flow for QUEST Program *(continued)*

- Prior to Discharge:
  - Written contact information given to patient & caregivers via ***Post D/C Follow Up***
  - Date confirmed with patient and caregivers for follow up call



Post Discharge Follow Up

PREMIER THERAPY embrace the difference

Facility Name: _____

Follow up call date: _____ Time: _____

Facility Phone: _____

Facility Contact: _____

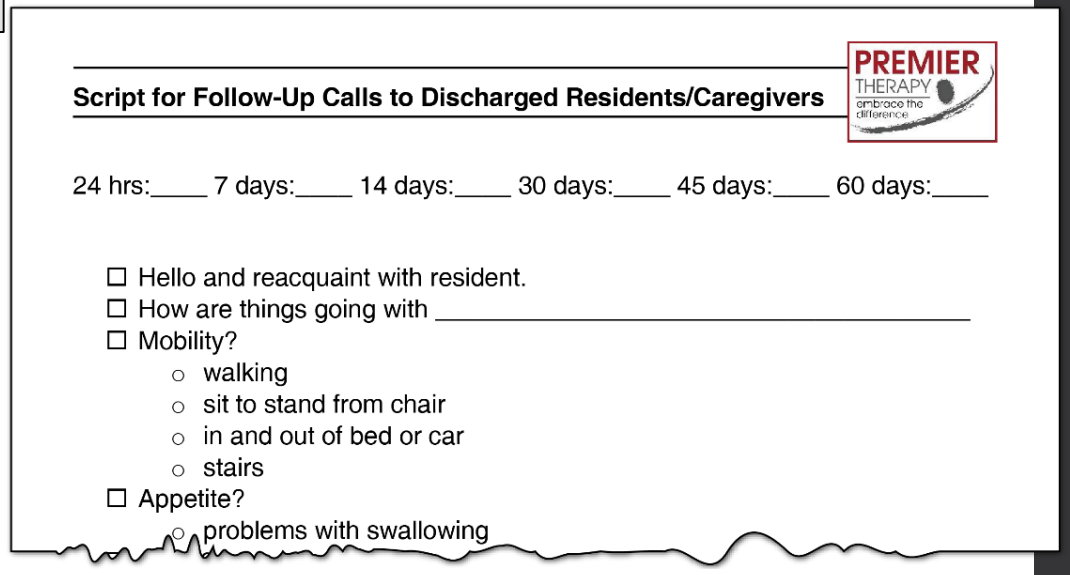
Facility Contact: _____

Facility Contact: _____

Therapy Contact: _____ _____ _____

Process Flow for QUEST Program *(continued)*

- Utilize ***Post Discharge Script*** for follow up call
- Complete on designated days
- Check compliance and status
- Give guidance as needed



Script for Follow-Up Calls to Discharged Residents/Caregivers

PREMIER THERAPY embrace the difference

24 hrs:____ 7 days:____ 14 days:____ 30 days:____ 45 days:____ 60 days:____

- ☐ Hello and reacquaint with resident.
- ☐ How are things going with _____
- ☐ Mobility?
  - ○ walking
  - ○ sit to stand from chair
  - ○ in and out of bed or car
  - ○ stairs
- ☐ Appetite?
  - ○ problems with swallowing

Questions?

Thank you!

Heather Meadows, CCC/SLP
Executive Director of PA, Certified Dementia Practitioner (CDP)
Premier Therapy

hmeadows@embracepremier.com

PREMIER THERAPY
embrace the difference

Resources and References

Care Transition Model Resources

- Transitional Care Model
- Bridge Program
- BOOST- Better Outcomes for Older adults through Safe Transitions
- GRACE- Geriatric Resources from Assessment and Care of Elders
- Guided Care
- Care Transitions Intervention (CTI)

Resources and References

Care Transition Intervention (CTI)
- Created by Eric A. Coleman, MD, MPH
- Division of Health Care Policy and Research at the University of Colorado Denver, School of Medicine
- www.caretransitions.org

Transitional Care Model (TCM)
- Created by Mary D. Naylor, PhD, RN, FAAN
- University of Pennsylvania School of Nursing
- www.transitionalcare.info/

Bridge Program
- Illinois Transitional Care Consortium
- http://hmprg.org/programs-projects/Illinois-transitional-care-consortium/

BOOST Program
- Society of Hospital Medicine
- http://www.hospitalmedicine.org/ResourceRoomRedesign/RRCareTransitions/CTHome.cfm

Resources and References

GRACE Program

- Dr. Steven R. Counsel, MD
- Indiana University Center for Aging Research, Indianapolis, Indiana
- http://medicine.iupui.edu/IUCAR/research/grace.asp

Guided Care

- Dr. Chad Boult, MD, MPH, MBA
- Johns Hopkins University
- http://www.guidedcare.org/

References

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2. https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/care-transitions/index.html
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7. Care Transitions: What do these programs look like? And how can the aging network play a role?, Administration on Aging, Accessed 7-1-2018.
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9. Joint Commission Resources, Hot Topics in Health Care, Transitions of Care: The need for a more effective approach to continuing patient care, Accessed July 2018.
10. Miller, Kenneth L., PT, DPT, GCS, CEEAA, Care Transitions, August 12, 2016.
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