Interventions to Improve Care Transitions and Reduce Readmissions

Use the following strategies on select interventions to help your organization reduce readmissions and improve the transition process.

Intervention Strategy	Description	Tools
Acute Setting		
Project Re-Engineered Discharge (RED) http://www.bu.edu/fammed/projectred/	**Project RED** is a standardized hospital-based program piloted by Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ) and the National Heart, Lung, and Blood Institute (NHLBI). The program has helped nearly 300 U.S. hospitals improve their discharge processes, resulting in significant readmission reductions at many sites. The Project RED intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction.	• Project RED Toolkit: https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf • Project RED Toolkit quick links: – Contact Sheet: https://www.ahrq.gov/sites/default/files/publications/files/contactsheet.docx – Post-Discharge Follow-up Phone Call Script: https://www.ahrq.gov/sites/default/files/publications/files/postdisphone.docx • Project RED patient booklet. *Taking Care of Myself: A Guide for When I Leave the Hospital*: https://www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf • Project RED Discharge Advocate Training Manual: http://www.bu.edu/fammed/projectred/publications/FINALTrainingManual.pdf
Better Outcomes for Older adults through Safe Transitions (BOOST) https://www.hospitalmedicine.org/clinical-topics/care-transitions/	**Project BOOST** is a discharge-focused program from the Society of Hospital Medicine. BOOST is designed to reduce preventable readmissions; improve provider workflow; reduce medication-related errors; and prepare and empower patients, families, and caregivers to improve discharge education.	• Project Boost Implementation Guide, Second Edition: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf • BOOST Implementation Guide quick links. – The 8P Screening Tool. Identifying Your Patient's Risk for Adverse Events after Discharge: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf – Patient PASS: A Transition Record. Patient Preparation to Address Situations (after discharge) Successfully: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/pass-3.pdf

Intervention Strategy	Description	Tools
Acute Setting (cont.)		
Transforming Care at the Bedside (TCAB) https://www.rwjf.org/en/library/research/2007/04/a-new-era-in-nursing.html	**TCAB**, a national partnership between the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement (IHI), is a unique model built around improvements in four main categories: • Safe and Reliable Care • Vitality and Teamwork • Patient-Centered Care • Value-Added Care Processes By working in all four improvement categories simultaneously, care teams can more effectively transform results. TCAB was developed as a way to improve care on medical-surgical units; improve patients' and family members' experience of care; encourage teamwork among care team members, and increase nurses' satisfaction and retention.	• TCAB Toolkit: https://www.rwjf.org/en/library/research/2008/06/the-transforming-care-at-the-bedside-tcab-toolkit.html • TCAB Framework: http://www.ihi.org/engage/initiatives/completed/TCAB/Pages/Framework.aspx • Transforming Care at the Bedside How-to Guide. Spreading Innovations to Improve Care on Medical and Surgical Units: http://www.ihi.org/resources/Pages/Tools/TCABHowToGuideSpreadingInnovations.aspx • A New Era in Nursing. Transforming Care at the Bedside. A step-by-step handbook: https://www.rwjf.org/content/dam/files/legacy-files/article-files/2/TCABBrochure041007.pdf
IDEAL Discharge Planning https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html IDEAL stands for Include, Educate, Assess, and Listen.	Created by AHRQ, **IDEAL Discharge Planning** is a toolkit designed to engage patients and their caregivers and prevent communication gaps between patients and healthcare providers. The program is one part of a holistic, evidence-based initiative to place the patient at the center of care, titled a *Guide to Patient and Family Engagement in Hospital Quality and Safety*.	• Care Transitions from Hospital to Home. IDEAL Discharge Planning Implementation Handbook: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Implement_Hndbook_508_v2.pdf • IDEAL Discharge Planning Overview, Process, and Checklist: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.docx • Be Prepared to Go Home Checklist and Booklet: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_2a_IDEAL_Checklist_508.docx • Improving Discharge Outcomes With Patients and Families. Handout for clinicians: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_3_Physician_HO_508.docx • *Care Transitions from Hospital to Home: IDEAL Discharge Planning Training.* A presentation for clinicians and hospital staff to support patient and family engagement related to discharge planning: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_4_PPT_508.pptx

Intervention Strategy	Description	Tools
Post-Acute Setting		
Interventions to Reduce Acute Care Transfers® (INTERACT®) https://pathway-interact.com/	**INTERACT** is a publicly available quality improvement program designed to improve identification, evaluation, and communication about changes in post-acute care resident status. The overall goal of the INTERACT program is to reduce the frequency of transfers to the acute hospital. Transfers to the hospital can be emotionally and physically difficult for residents, can result in numerous complications of hospitalization, and are costly. There are four basic types of INTERACT tools: 1. Quality Improvement tools 2. Communication tools 3. Decision Support tools 4. Advance Care Planning tools	• INTERACT Tools: https://www.med-pass.com/index.php/interact-4 – Quality Improvement Tool for Review of Acute Care Transfers – SBAR (situation, background, assessment, recommendation) Communication Form – Medication Reconciliation Worksheet for Post-Hospital Care – SNF/NF (skilled nursing facility) Capabilities List – SNF/NF Hospital Transfer Form – Acute Care Transfer Checklist – Hospital to Post-Acute Care Data List – Acute Change in Condition Flip Chart – Care Paths – Advance Care Planning Communication Guide – Identifying Residents Appropriate for Hospice or Comfort Care – Comfort Care Order Set • INTERACT Version 4.5 Tools for Skilled Nursing: https://pathway-interact.com/interact-version-4-5-tools-tools-for-nursing-homes • INTERACT Version 1.0 Tools for Assisted Living: https://pathway-interact.com/interact-tools/interact-version-1-0-tools-for-assisted-living/ • INTERACT Version 1.0 Tools for Home Health Care: https://pathway-interact.com/interact-tools/interact-version-1-0-tools-for-home-health-care/
Multidisciplinary Setting		
Care Transitions Intervention® (CTI) (Coleman Model) http://www.caretransitions.org	Developed by Eric Coleman, MD, at University of Colorado, School of Medicine in 2003, **CTI** is an evidence-based, short-term model that complements a system's care team by activating patient engagement in their own health management. Through the guidance of a Transitions Coach®, patients will identify a 30-day goal, practice skills, and gain confidence in four key areas of health, known as the Four Pillars®: 1. Medication Self-Management 2. Dynamic, Patient-Centered Recordkeeping 3. Follow Up 4. Red Flags	• Personal Health Record: https://caretransitions.org/wp-content/uploads/2015/06/phr.pdf • Discharge Preparation Checklist: https://caretransitions.org/wp-content/uploads/2015/06/Discharge-Checklist-RWJF-Website.pdf • Medication Discrepancy Tool (MDT): https://caretransitions.org/wp-content/uploads/2015/08/MDT.pdf • Patient Activation Assessment® (PAA®): https://caretransitions.org/wp-content/uploads/2015/

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