

Key Elements of The Care Transitions Intervention™

- Low-cost, low-intensity, adapt to different settings
- One home visit, three phone calls over 30 days
- “Transition Coach” is the vehicle to transfer skills, build confidence and provide tools to support self-management
 - Model behavior for how to handle common problems
 - Reconcile pre- and post-hospital medications
 - Practice or “role-play” next encounter or visit
- Generous support of John A. Hartford Foundation

Care Transitions Intervention™

Summary of Key Findings

- Significant reduction in 30-day hospital readmits
- Significant reduction in 90-day & 180-day readmits
- CMS Study--50% reduction in 60-day readmits
- Net cost savings of \$300,000 for 350 pts/12 mo
- Adopted by over 145 leading health care organizations nationwide
- The CTI Model is in the public domain
- www.caretransitions.org

SHM Initiatives

- Discharge Checklist

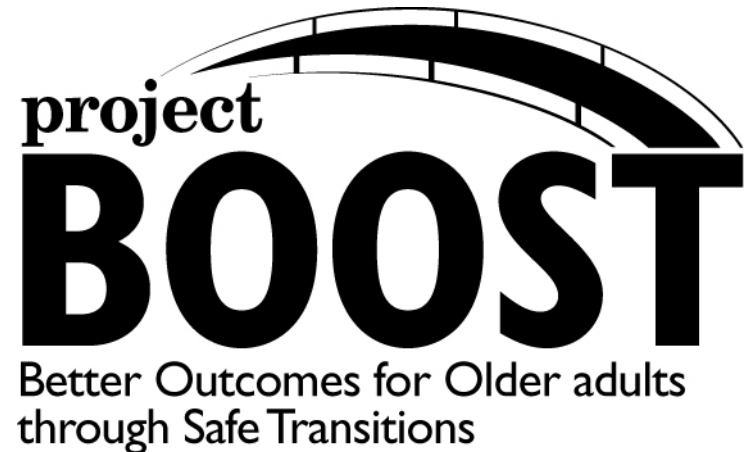
Halasyamani L et al. Transition of care for hospitalized elderly patients --development of a discharge checklist for hospitalists. *J of Hosp Med* 2006:354.

- Resource Room

- Safe STEPs

- Project BOOST

- **Better Outcomes for Older adults through Safe Transitions**
- John A. Hartford Foundation \$1.4 million



BOOST Toolkit: Primary Components

- Tool for Identification of High-Risk Patients
- Patient and Family/Caregiver Preparation
 - Diagnosis – primary cause for hospitalization and other Dx
 - Test results and interpretation
 - Treatment Plan during and after hospitalization
 - Contextualize
 - Follow-up Plans
 - Principal Care Provider identification
 - Who to contact with questions/concerns
 - Warning signs/symptoms and how to respond
 - Outpatient appointments
 - Pending tests
 - Medication Reconciliation
- Discharge Summary Communication

BOOST Toolkit: Secondary Components

- Determining Cultural Readiness
- Assessing knowledge base and gaps
- Teamwork
- Sales program (C-Suite and Staff)
- Evaluation Plan (local)

BOOST - 30 Mentor Sites

