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QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Improving Care Transitions

A Guide to Tools & Resources for Providers and Patients

There are several resources and tools available that can be implemented to improve care transitions (or care coordination) between settings and reduce potentially avoidable hospital utilization. The purpose of this guide is to share some evidence-based interventions, best practices and other supportive materials, in one location. Additional resources for care coordination, such as medication reconciliation tools, are on the IPRO QIN-QIO Resource Library: https://qi-library.ipro.org.

All Care Settings

Institute for Healthcare Improvement (IHI): STAAR (STate Action on Avoidable Readmissions) Initiative	https://bit.ly/3Ik0XxO	The IHI site includes How to Guides for improving transitions from: - hospital to community - hospital to home health care - hospital to clinical office practices - hospital to skilled nursing facilities Login is required but guides are available at no cost.
Project RED (Re-Engineered Discharge)	https://www.bu.edu/fammed/projectred https://www.bu.edu/fammed/projectred/toolkit.html	The RED toolkit provides implementation guidance and five tools with step-by-step instructions for hospitals to proactively address avoidable readmissions.
Society of Hospital Medicine Project BOOST® Better Outcomes by Optimizing Safe Transitions (Second Edition)	https://www.hospitalmedicine.org/clinical-topics/care-transitions	Project BOOST® site has several resources for enhancing care transitions, including online modules and an implementation guide.
Interventions to Reduce Acute Care Transfers (INTERACT®)	https://pathway-interact.com/interact-tools/interact-tools-library	INTERACT® is designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents. The goal is to improve care and reduce potentially avoidable transfers to the hospital. Register and log-in to download the tools at no cost.

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All Care Settings (continued)		
INTERACT®: Implementation Guide	https://bit.ly/3OQiSPn	This guide provides an overview of the evidence based INTERACT® tools, and strategies to implement them.
Acute Care Transfer Checklist	https://pathway-interact.com/wp-content/uploads/2021/08/21-INTERACT-Acute-Care-Transfer-Checklist-2021.pdf	Other INTERACT® tools to help ensure successful transfer of resident information between the nursing home and the hospital are also included here.
Nursing Home to Hospital Transfer Form	https://pathway-interact.com/wp-content/uploads/2021/08/19-INTERACT-SNF_NF-Hospital-Transfer-Form-06-17-2021.pdf	Other INTERACT® tools to help ensure successful transfer of resident information between the nursing home and the hospital are also included here.
Project RED (Re-engineered Discharge) for Nursing Homes	https://healthcentricadvisors.org/wp-content/uploads/2019/09/CompleteToolkit.pdf	This guide includes a range of tools and resources to enhance the discharge process and reduce readmissions. All materials were developed from evidence-based resources and adapted to the nursing home care setting.
Toolkit to Engage High-Risk Patients in Safe Transitions Across Ambulatory Settings, Agency for Healthcare Research and Quality (AHRQ)	https://www.ahrq.gov/hai/tools/ambulatory-care/safe-transitions.html	Patients who transition from one ambulatory care facility clinician to another are especially vulnerable to patient safety errors. This toolkit from AHRQ is designed to help staff actively engage patients and their care partners to prevent errors during transitions of care.
Hospital Discharge Planning		
Care Transitions from Hospital to Home - IDEAL Discharge Planning	https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html	To promote stronger patient engagement, AHRQ developed the Guide to Patient and Family Engagement in Hospital Quality and Safety, a tested, evidence-based resource to help hospitals work as partners with patients and families to improve quality and safety.

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Hospital Discharge Planning (continued)		
Transitional Care Model (TCM)	https://www.nursing.upenn.edu/ncth/transitional-care-model	TCM is led by an advanced practice nurse who visits the patient, while in the hospital, and then follows the patient upon discharge for a 6-8 week period. Focus is on teaching the patient how to manage their chronic illness and collaboration with the physician.
Post-Discharge Follow-up Script, Re-Engineered Discharge (RED) Toolkit	https://www.ahrq.gov/patient-safety/settings/hospital/hai/red/toolkit/redtool5.html	The post-discharge follow up phone call, the 12th component of RED, is an essential part of supporting the patient from the time of discharge until the first follow-up appointment.
Assessing Risk for Readmission		
BOOST 8Ps Screening Tool from Project BOOST® (Better Outcomes by Optimizing Safe Transitions)	https://www.hospitalmedicine.org/clinical-topics/care-transitions	The 8 P's screening tool from Project BOOST® helps identify a patient's risk for adverse events after discharge.
ASPIRE Guide: Designing and Delivering Whole-Person Transitional Care; The Hospital Guide to Reducing Medicaid Readmissions	https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html	This guide from AHRQ includes evidence-based strategies to reduce readmissions and has been updated with clearer guidance on who should use the tools. It also offers tools that can be used in the day-to-day working environment of hospital-based teams and cross-setting partnerships.
LACE tool	https://www.hsag.com/contentassets/e449c71c3b214699931b05644b15cbd6/modifiedlacetoolfinal508.pdf	LACE is designed to assess a patient's risk for readmission to the hospital. LACE is a point-system, assigning numerical values for Length of stay, Acuity on admission, Comorbidity, and Emergency department visits.
Patient-Facing Tools		
Patient PASS: A Transition Record Tool (Project BOOST® Better Outcomes by Optimizing Safe Transitions)	https://www.hospitalmedicine.org/clinical-topics/care-transitions	The Patient Preparation to Address Situations (after discharge) Successfully (PASS) is a patient-facing guide to help with appointments, contact information and action plans.
Taking Care of Myself: A Guide for When I Leave the Hospital (AHRQ)	https://bit.ly/3P161cW	Use this easy-to-read guide with patients during discharge to help them care for themselves when they leave the hospital, and track their medication schedules, upcoming medical appointments, and important phone numbers.

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Patient-Facing Tool (continued)		
Care About Your Care Discharge Checklist & Care Transition Plan (RWJF)	https://rwjf.ws/3NPEgCZ	*Care About Your Care* checklist can help patients and caregivers keep track of their care plan after leaving the hospital.
My After Nursing Home Care Plan	https://qi-library.ipro.org/2022/01/25/my-after-nursing-home-care-plan	This tool was completed by nursing home interdisciplinary teams with the patient and caregiver throughout the discharge planning process. Adapted based on materials from Agency for Healthcare Research and Quality, Project RED, and the Coleman Transitions Intervention.
Home Care: What it is, Why it Matters	bit.ly/3yWdX9O	Resource for Patients and Families on the benefits of home care.
My Shared Care Plan	http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx	*My Shared Care Plan* facilitates communication between patients/clients and health care professionals to support long-term planned care for patients with chronic illnesses, such as diabetes or congestive heart failure. It gives patients a tool to learn about and practice principles of self-management, producing activated and engaged patients. In addition, it gives health care professionals a communication tool to provide timely information that supports planned care and patient self-management.
Addressing SDoH & Disparities		
IPRO QIN-QIO Social Determinants of Health - Guide to Getting Started	https://bit.ly/3yQtyYJ	Screening for and meeting social needs of patients is key for better outcomes and reduced hospital utilization. This resource guide provides national search tools to find local/state programs or services to help meet SDoH needs.
Screening for Social Determinants of Health: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	https://www.chcs.org/media/Redwood-PRAPARE-Questions_102517.pdf	PRAPARE is a national, standardized patient risk assessment protocol that allows providers to collect patient-level data on the social determinants of health.

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Addressing SDoH & Disparities (continued)		
How to Deliver Project RED (Re-engineered Discharge) to Diverse Populations	https://www.bu.edu/fammed/projectred/newtoolkit/ProjectRED-tool4-diverse-pop.pdf	This guide outlines a culturally informed approach to ensure the effective delivery of Project RED to patients from diverse backgrounds, including diverse language, culture, race, ethnicity, education, and literacy, and social circumstances. It also includes some proactive communication and relational strategies.
Society of Hospital Medicine's PArTNER (PATient Navigator to rEduce Readmissions) Model	https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/Partner_Model_Guide_2016-12.pdf	PArTNER is a transitional care model that is specifically targeted to Minority-Serving Institutions. It encourages increased support to patients and caregivers at the hospital through the transition home to reduce readmission rates and patient anxiety.
Centers for Medicare & Medicaid Services: Guide to Reducing Disparities in Readmissions	https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf	This guide provides an overview of key issues related to readmissions for racially and ethnically diverse Medicare beneficiaries, as well as useful resources for hospitals.
Caring for Those Who Care: Resources for Providers Meeting the Needs of Diverse Family Caregivers Toolkit	https://qi-library.ipro.org/2021/08/19/caring-for-those-who-care-resources-for-providers-meeting-the-needs-of-diverse-family-caregivers	This toolkit offers information for providers ready to learn how to support diverse family caregivers. It focuses on what providers need to know to help them build a more welcoming, supportive practice.
End-of-Life Care		
IPRO QIN-QIO **Advance Care Planning and End-of-Life Care Guide**	https://bit.ly/3bZyelK	This guide provides a curated list of tools and resources to support patients and providers through the ACP process, and serious illness or end-of-life care conversations. ACP can help reduce hospital readmissions and ensure patients receive the care they want.
Patient & Family Engagement		
Guide to Patient and Family Engagement	https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/index.html	Research shows that when patients are engaged in their health care, it can lead to measurable improvements in safety and quality. To promote stronger engagement, AHRQ developed a guide to help patients, families, and health professionals work together as partners to promote improvements in care.

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Patient & Family Engagement (continued)		
Go to the Hospital or Stay Here? The Decision Guide	http://www.decisionguide.org	This guide helps residents/ patients, families and caregivers understand why transfers to hospital are made and how they can be involved in the decision.
The Family Caregiver Activation in Transitions® (FCAT®) Tool	https://caretransitions.org/wp-content/uploads/2019/09/Family-Caregiver-Activation-in-Transitions-FCAT-tool.pdf	The FCAT tool was developed as part of the Care Transitions Intervention (CTI) model to foster communication between health care professionals and family caregivers. The FCAT tool is administered by a health professional or self-administered by the family caregiver, to identify what needs to be addressed during discharge preparation instructions.
Caregiver Advise, Record, Enable (CARE) Act.	https://www.aarp.org/ppi/initiatives/supporting-family-caregivers-providing-complex-care	***Under the CARE Act, hospitals must identify a family caregiver for inpatient admissions and make a note in the medical record; notify the family caregiver of discharge plans; and offer family caregivers training on medical tasks they may be asked to perform.*** AARP Public Policy Institute has released papers to provide information and guidance about the value and complexity of CARE Act implementation. Use these papers to inform your practice recommendations to recognize and support family caregivers.
Person and Family Engagement (PFE) Implementation Guide for Hospitals - Discharge Planning Checklist. *From IPRO HQIC and American Institute of Research (AIR)*	https://hqic-library.ipro.org/2021/12/20/person-and-family-engagement-implementation-guides-for-hospitals From this page, select: Guide Practice 2: Discharge Planning Checklist	This resource provides hospital leaders and staff with practical, step-by-step guidance to successfully implement a discharge planning checklist, which is one of the five Person and Family Engagement (PFE) Best Practices in the CMS-funded Hospital Quality Improvement Contract (HQIC) program.
Teach-back Intervention, AHRQ	https://www.ahrq.gov/patient-safety/reports/engage/interventions/teachback.html	Teach-back is a technique for health care providers to ensure that they have explained medical information clearly so that patients and their families understand what is communicated to them. This Guide provides clinicians and practice staff with five simple steps for implementing teach-back in the office setting.

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