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| **KEY COMPONENTS OF BEST PRACTICES IN PERSON CENTERED HOSPITAL DISCHARGE PLANNING** |
| **Evidence-Based Model**  | **Concept summary**  | **Efficiency; Starting @ Admit**  | **Individualized Assessment**  | **Patient Education (Post-Op Care & Meds)**  | **Families and Informal Supports**  | **Maximizing Resources & Coordinating Care**  | **Discharge Follow-up**  |
| **Re-Engineering Discharge** **(RED; Boston)** **Jack & Bickmore**  | *Nurse Discharge Advocate* coordinates services with the team  | Prior to discharge (variable)  | Assessment focuses on reconciling conflicts between medications, post-of care and physician orders  |  “teach back” review of care, medications, physician contacts & written copy of plan  | Family members contacted only if patient understanding of self-care is limited  | Coordinate services by making appointments and organize post-discharge services. | Faxes plan to primary care provider; medication follow-up with the pharmacist via telephone  |
| **Care Transitions Intervention (CTI; Denver)** **Waves.jpgColeman**  | *Team transition coach* (nurse, social worker, community worker, etc) coordinates primary and specialty care with personal health record.  | Team transition coach meets patient @ hospital prior to discharge; timing?  | In-hospital assessment and development of an “evidence-based care plan”  | List “red flags” for worsening care conditions and instructions for how to respond; assistance with medication management  | Includes caregivers as appropriate to each individual situation encouraging them to take an active role in care transitions  | Coordination of services thruenhanced info exchange with health information technology across care settings. Set appts., if needed | Home visits and telephone calls by transition coach  |
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| **Transitional Care Model (TCM; Philadelphia) Naylor**  | *Transitional care nurse* responsible for coordination  | Immediate assignment of TCN for an assessment and daily meeting with patient. | Individualized assessment for discharge plan needs  | Education regarding health care risks and symptoms  | Family and informal support caregivers are involved in process  | Coordination of services includes Emphasis on interdisciplinary approach and streamlined, evidence based plan of care | Home visits and telephone support by TCN; Coordinated contact with PCP  |
| **Guided care** **(Baltimore / DC)** **Boult**  | *Guided care nurse* assesses and facilitates transitions  | GCN assigned for assessment  | Comprehensive in-home assessment for Guided Care Plan  | Motivational interviewing for patient education & self-management  | Education and support of the family is part of the process  | “smoothes” transitions and facilitates access to community resources  | Monthly monitoring by GCN at least by phone to monitor symptoms and level of adherence to the patient’s Action Plan. |

