|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 thru  enhanced info exchange with health information technology across care settings. Set appts., if needed | Home visits and telephone calls by transition coach |
| **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** |
| **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. |

Waves.jpg