

# Care Transition Bundle

Working  
DRAFT  
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Primary Care	Assisted Living/LTC/ Subacute Care	Home Health	Acute Care	Senior Housing
<b>Primary Care</b> * Medical Home Practices	Bennington Health & Rehabilitation Crescent Manor Fillmore Pond Centers for Living & Rehabilitation Vermont Veterans Home	Bayada Nurses Manchester Health Services VNA & Hospice	Southwestern Vermont Medical Center (SVMC)	Support and Services at Home (SASH)
1. Panel management* 2. Establish patient self-management goals* 3. Use of registry for disease management* 4. Follow-up appointment within 3 – 5 days of discharge 5. Coordination with specialty care includes medication reconciliation 6. Referral to Healthy Living Workshop 7. Referral to practice Behavioral Health Specialist* 8. Electronic notification of 30-day readmissions, ED visits	1. INTERACT protocols 2. Discharge medication reconciliation 3. Teachback process 4. Post discharge telephone call 5. Post discharge appointment 6. "Pause" prior to all non-urgent/emergent hospitalizations 7. 72 Hour admission conference 8. Consistent primary nurse assignments 9. Standardized SBAR for physician calls 10. NP management of chronic diseases for early symptom recognition	1. Telehealth for COPD and HF patients 2. Post discharge home visit for medication reconciliation 3. Use of smart phones in the field 4. Use of teachback for patient education 5. Post discharge home visit on all patients with a rehospitalization within 30-days 6. Establish SBAR/information needed by the VNA for all referrals 7. Liaison attendance at Huddles and Discharge planning meetings for warm hand-off and SVMC and CL&R 8. COPD and HF management templates 9. Electronic notification of readmissions to hospital 10. Standardized protocols and education materials	1. Teachback 2. Discharge medication reconciliation 3. Post discharge appointment 4. Post discharge follow-up call 5. Discharge summary to primary care upon discharge 6. Patient education packet (BOOST) 7. Discharge risk assessment 8. Continuity of SVMC case management to CL&R 9. Pharmacist patient consult on high risk medications/diagnoses 10. Team Huddles	1. Resident assessment 2. Care coordination 3. Facilitate care transitions 4. Schedule and remind resident of Appointments 5. Maintain individual wellness record
 <b>Care Coordination &amp; Facilitation</b> <b>Structured Communications (SBAR)</b> 				
<b>Measures</b> Patient satisfaction Rate of 30-day hospital admissions Ambulatory sensitive hospital admissions Rate of ED visits Disease registry outcomes for chronic disease and preventive health Number of hospital days at the last six months of life	<b>Measures</b> Patient satisfaction Rate of 30-day hospital readmissions Rate of unplanned discharges	<b>Measures</b> Patient satisfaction Rate of 30-day hospital readmissions Rate of ED visits Rate of hospital admissions	<b>Measures</b> Patient satisfaction Rate of 30-day hospital readmission Core measure outcomes	<b>Measures</b> Rate of 30-day hospital readmissions Rate of ED visits
 <b>Information Technology</b> 				