



Acute Care and Psychiatric Facility Change Package

Provider Name: _____ Date: _____

Provider Number: _____ Name of Provider Contact Person: _____

Please Check One or More	Interventions	Targeted Population (Ex: Heart Failure, PN, or AMI Patients)	Planned Start Date	Actual Start Date
1. Foster Patient/Family Self-management				
	1a. Give the patient a Personal Health Record (PHR) and instructions for use.			
	1b. Give the patient a <i>Planning for Your Discharge</i> checklist and assist patient in planning process.			
2. Patient/Caregiver Education				
	2a. Enhance video system programming (e.g., Get Well Network) to include information about Care Transitions, the goals of patient self-management, the PHR, <i>Planning for your Discharge</i> checklist, and other resources that promote knowledge and self-management.			
	2b. Educate the patient on diagnosis, related care needs, medications, and recognition of “red flags” daily throughout the hospital stay and reinforce at discharge.			
	2c. Redesign the patient education process to include “Teach Back” to assess the patient’s/caregivers’ understanding of discharge instructions, medication management, and the ability to provide self-care.			



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3. Advance Care Planning				
	3a. Review Advance Care Plans with targeted patient/caregiver during each admission and provide information on different plans (DNR, DNI, DNH, Palliative Care, Hospice Care).			
	3b. Implement a comprehensive Palliative Care Program with patient -specific plans that are communicated to physicians and “down-stream” healthcare providers.			
4. Discharge Planning				
	4a. Include patient and caregivers as full partners in discharge planning and predicting home-going needs and familiarize them with community resources.			
	4b. Develop interdisciplinary goal-focused Plan of Care.			
	4c. Establish method for interdisciplinary assessment of readiness for discharge.			
	4d. Ensure medication reconciliation at time of discharge.			
5. Patient- and Family-centered Handover Communication				
	5a. Provide customized, real-time critical information to the next care provider (Home Health, Nursing Home, Hospice, Inpatient Rehab Hospital, Dialysis Facility, etc.). <ul style="list-style-type: none"> • Implement web-based care tool subset for discharges to “down-stream” providers • Use verbal communication for at least 90% of discharges to “down-stream” providers 			
	5b. Redesign the process of transferring information from the hospital to the patient’s follow-up physician so that critical information about the patient’s hospitalization is received by the physician within two days of discharge.			

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6. Post-acute Care Follow-up				
	6a. High-risk patients: <ul style="list-style-type: none"> • Prior to discharge, schedule/facilitate a face-to-face follow-up visit (home care visit, care coordination visit, or physician office follow-up) to occur within 48 hours after discharge • Provide telephone reinforcement of the discharge plan and assist the patient in problem solving 2-3 days after discharge 			
	6b. Moderate-risk patients: Prior to discharge, schedule a follow-up phone call within 48 hours and schedule/facilitate a physician office visit within 5 days after discharge.			
	6c. Lower-risk patients: Encourage patient/caregiver to schedule a physician office follow-up visit within 21 days after discharge.			
	6d. Implement Transitions Coach Model of three follow-up phone calls (two, seven, and 14 days after discharge) and home visit that includes coaching regarding: PHR, physician follow-up, “recognition of red flags,” and medication self-management.			
	6e. Implement Transitional Care Nurse (TCN) Model to include daily in-hospital coordination of care and follow-up care at home, including regular home visits with telephone support, active engagement of patients/families, and physician-nurse collaboration.			

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7. Emergency Department				
	7a. Increase “Use of Observation Status” to prevent readmission.			
	7b. Increase “Use of Intensive Treatment Protocols” to prevent readmission.			
	7c. Develop communication linkages with physician offices and “down-stream” providers.			
8. Other Facility-chosen Interventions				