

<i>Title</i>	<i>Source</i>	<i>Description</i>
"Project RED (Re-Engineered Discharge)" (Boston University)	<a href="http://www.bu.edu/fammed/projectred/">http://www.bu.edu/fammed/projectred/</a>	Project <b>Re-Engineered Discharge</b> is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components, and has been proven to reduce re-hospitalizations and increase patient satisfaction.
"Care Transitions Program®" (University of Colorado)	<a href="http://www.caretransitions.org/">http://www.caretransitions.org/</a>	During a four-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home.
"Project BOOST" (Society of Hospital Medicine)	<a href="http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=27659">http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=27659</a>	"Better Outcomes for Older Adults through Safe Transitions," a national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home.
"TCM Overview" (Transitional Care Model)	<a href="http://www.transitionalcare.info/">http://www.transitionalcare.info/</a>	The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The heart of the model is the Transitional Care Nurse (TCN), who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. While TCM is nurse-led, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists and other members of the health care team in the implementation of tested protocols with a unique focus on increasing patients' and caregivers' ability to manage their care.

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“Medicare Demonstrations: Details for Community-Based Care Transition Program” (U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services)	<a href="http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313">http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313</a>	The Community-Based Care Transitions Program (CCTP) goals are: to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. The demonstration will be conducted under the authority of Section 3026 of the Affordable Care Act of 2010.
<i>Care Transitions in Action: From Hospital to Home in Two Communities</i> (U.S. Department of Health & Human Services, Administration on Aging)	<a href="http://www.swscoa.org/forms/2011Publications/AoA_ACA_Webinar.pdf">http://www.swscoa.org/forms/2011Publications/AoA_ACA_Webinar.pdf</a>	Social worker-based hospital to home care transitions program.
“An Early Look at a Four-State Initiative to Reduce Avoidable Hospital Readmissions” (Institute for Healthcare Improvement [IHI])	<a href="http://www.ihl.org/knowledge/Pages/Publications/AnEarlyLookFourStateInitiativetoReduceAvoidableReadmissions.aspx">http://www.ihl.org/knowledge/Pages/Publications/AnEarlyLookFourStateInitiativetoReduceAvoidableReadmissions.aspx</a>	State Action on Avoidable Rehospitalizations (STAAR) aims to reduce rates of avoidable rehospitalization in Massachusetts, Michigan, Ohio, and Washington by mobilizing state-level leadership to improve care transitions. It includes enhanced assessment of post-discharge needs, enhanced teaching and learning, enhanced communication at discharge, and timely post-acute follow-up.
“Health Care Leader Action Guide to Reduce Avoidable Readmissions” (Health Research & Educational Trust)	<a href="http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jan/Readmission%20Guide/Health%20Care%20Leader%20Readmission%20Guide_Final.pdf">http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jan/Readmission%20Guide/Health%20Care%20Leader%20Readmission%20Guide_Final.pdf</a>	This resource guide is designed to serve as a starting point for hospital leaders to assess, prioritize, implement, and monitor strategies to reduce avoidable readmissions.
“Heart Failure Resource Center” (Health Workforce Solutions [HWS])	<a href="http://www.innovativecaremodels.com/care_models/15">http://www.innovativecaremodels.com/care_models/15</a>	Evidence-based clinical care protocols; outpatient care for chronically ill patients with heart failure.
“Chronic Care Coordination” (HWS)	<a href="http://www.innovativecaremodels.com/care_models/13">http://www.innovativecaremodels.com/care_models/13</a>	Through mostly phone-based interactions, nurses help complex patients and patients transitioning between care settings understand their care plans and instructions and access the clinical services they need.
“Transforming Care at the Bedside” (IHI)	<a href="http://www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm">http://www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm</a>	Admission assessment for post-discharge needs; teaching and learning; early post-acute care follow-up; patient and family-centered handoff communication.

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“INTERACT: Interventions to Reduce Acute Care Transfers” (Florida Atlantic University)	<a href="http://www.interact2.net/">http://www.interact2.net/</a>	The overall goal of the INTERACT program is to reduce the frequency of transfers to the acute hospital, using three basic types of tools: 1) communication tools; 2) care paths or clinical tools; and 3) advance care planning tools.
“GRACE Team Care: Geriatric Resources for Assessment and Care of Elders” (Indiana University)	<a href="http://www.americangeriatrics.org/files/documents/annual_meeting/2010/handouts/saturday/care_coordination/S0230P_S_Counsel.pdf">www.americangeriatrics.org/files/documents/annual_meeting/2010/handouts/saturday/care_coordination/S0230P_S_Counsel.pdf</a>	The GRACE model improves health and reduces healthcare costs by lowering hospitalization rates in high-risk seniors. The GRACE intervention can be financed by a health plan under managed care Medicare, using the savings from fewer hospitalizations to offset GRACE program expenses.
“HealthCare Partners: Medical Group and Affiliated Physicians”	<a href="http://www.healthcarepartners.com/">http://www.healthcarepartners.com/</a>	Uses risk assessment to stratify patients and match to four levels of programs; special programs for frail patients.
“Chronic Care for Low Income Frail Elderly” (John Muir Health)	<a href="http://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-alliance/our-programs/caregiver-senior-programs-services/chronic-care-low-income-frail-elderly.html">http://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-alliance/our-programs/caregiver-senior-programs-services/chronic-care-low-income-frail-elderly.html</a>	“Transforming Chronic Care” improves the coordination of care for low-income, frail, elderly patients through phone support and site visits. Transforming Chronic Care has four component programs: Care Transitions Intervention; Tel-Assurance; Disease Management; and Complex Case Management.
“Sharp Rees-Stealy Medical Centers” (Sharp HealthCare)	<a href="http://www.sharp.com/rees-stealy/">http://www.sharp.com/rees-stealy/</a>	Transitions program for those nearing the end of their lives.
“Transition Home Program Reduces Readmissions for Heart Failure Patients” (U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality)	<a href="http://innovations.ahrq.gov/content.aspx?id=2206">http://innovations.ahrq.gov/content.aspx?id=2206</a>	The Transition Home for Patients with Heart Failure program at St. Luke’s Hospital in Cedar Rapids, IA, incorporates a number of components to ensure patients a safe transition to home or another health care setting. These components include enhanced assessment of post-discharge needs at admission, thorough patient and caregiver education (“teach-backs”), patient-centered communication with subsequent caregivers at handoffs, and a standardized process for post-acute care follow-up (home visit, post-discharge phone calls and outpatient classes). The program reduced the 30-day readmission rate for heart failure patients from 14 to 6 percent.

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"Quality Improvement Organizations" (Colorado Foundation for Medical Care)	<a href="http://www.cfm.org/integratingcare/toolkit.htm">http://www.cfm.org/integratingcare/toolkit.htm</a>	A toolkit designed by the National Coordinating Center (NCC) for the Integrating Care for Populations and Communities Aim (ICPCA), which helps Medicare Quality Improvement Organizations (QIOs) to promote seamless transitions between health care settings.