

Vision

The Integrated Care Management (ICM) Transitions of Care (TOC) program is founded on the principles of ICM, which are person-centered, evidence-based care delivery promoting care coordination and supporting patients across providers, settings and time. ICM TOC further builds upon the Joint Commission’s seven foundations of safe care transitions and defines the specific ICM practices that are critical in the provision of the expert care needed during the vulnerable time of a care transition.

Change Vision

- Advocate for patients and families to ensure their needs are met as they transition across providers, settings and time.
- Coordinate and facilitate continuity of care, with a focus on avoiding complications and reducing re-hospitalizations.
- Identify “at risk” patient populations and employ key evidence-based transition interventions across care settings.
- Develop provider competencies to support all care transitions by functioning as a prepared, proactive health literate care team.

Outcomes

The ICM TOC Program is designed to achieve the Triple Aim of health care reform: Better health, better care and lower cost.

Core Principles

Patient/family action/engagement

Works toward patients taking actions to drive the greatest benefits from the health care system. Patient values, needs and preferences drive care. Enhances patient’s:

- Motivation
- Information
- Skills and confidence

Early identification for “at risk” patients

- More resource allocation for high risk patients
- Screens for common barriers to self-management support (SMS)
- Uses best interventions to mitigate risks

Transitions planning

- Uses protocols to standardize care
- Ensures care is timely/24-hour availability
- Focuses care on key transition pillars

Medication management

- Screens for risk for future medication mismanagement
- Thorough medication reconciliation process
- Focus on medication management support

Multidisciplinary collaboration

- High functioning team principles
- Care management and collaboration

Transfer of information

- Communication best practices
- Meaningful data exchange

Leadership support

- Patient is the most important team member
- Seeks transformational change
- Accountable for outcomes
- Creates a culture of learning that values teams

Core Practices, Tools and Resources

Informed/Activated person

- Motivational Interviewing
- Universal precaution approach to health literacy
- Teach-back/patient Situation, Background, Assessment, Recommendation (SBAR)
- Confidence ruler/pros and cons/SMART goals
- Personal health record (PHR)/stoplight forms

Early Identification of risk

- Identify high risk patients: IHI risk tool
- Assessment of barriers for self-management support:
 - PHQ 2 and 9
 - Health literacy
 - Confidence
 - Self assessment of health

Transitions planning

- In home visit for high risk patients within 24 hours
- Initial visit focus: red flags, medication reconciliation, follow-up, PHR

Medication management

- Medication risk assessment, mini-cog assessment
- Focused medication management visit
- Patient-friendly medication lists and high risk medication stoplights

Multidisciplinary collaboration

- Case conference high risk patients
- SBAR for meaningful information exchange
- Accountable for team process and outcome metrics

Transfer of information

- Referral intake note
- SBAR
- PHR

Leadership

- Change vision/celebrate short term wins by sharing positive stories/storytelling
- Rounding for outcomes with multidisciplinary case conference
- Utilize behavior change principles to change care delivery practices of clinical and support staff