TABLE 1.
Care Transitions Models

Model	Setting	Tools/Components	Key Findings
Transitional Care Model (TCM): https://consultgeri.org/geriatric-topics/transitional-care	Hospital to home	• In-hospital evidence-based nursing care plan • Home visits þ phone follow-up with TCN • Holistic focus • Patient & caregiver education & support • Early identification & response • Patient & caregiver on team • Physicianenurse Collaboration • Open cross-communication • TCM hospital discharge screening tool for high risk older adults	• Reduced hospital readmissions • Decreased emergency room visits • Decreased healthcare costs
Care Transitions Intervention (CTI): http://www.caretransitions.org	Hospital to home	4 Pillars of CTI: • Medication • Personal health record (PHR) • Follow-up ◦ Transition Coach℠ ▪ Hospital visit ▪ Home visit ▪ 3 phone calls • Red flags	• Self-sustaining • Re-hospitalization rates @ 50% • Cost effective
Better Outcomes for Older Adults Through Safe Transitions (BOOST): http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/Overview.aspx http://caretransitions.org/tools-and-resources/	Hospital to home	• The target • Patient preparation to address situations (after discharge) successfully (patient PASS) • Teach-back process • Risk specific interventions • Written discharge instructions • Technical assistance	• Reduced 30-day readmission rates • Tools well-received by healthcare team and patients • Hospital and primary care provider communication and collaboration
Project Re-engineered Discharge (RED): http://www.bu.edu/fammed/projectred/	Hospital to home	• Diagnosis-related education • Post-discharge appointments, tests, etc. • Medications, diet, exercise-related education • Discharge plan reconciliation with national guidelines/clinical pathways • Emergency plan • Discharge summary transmission • Written discharge plan • Telephone call in 2e3 days	• Decreased 30-day re-hospital utilization and emergency room use • Reduced costs per subject enrolled • Increased revenue per discharge
Chronic Care Model (CCM): http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model	Clinic to home	• Community • Health care system • Self-management support • Delivery system design • Decision support • Clinical information systems • Organization assessment of chronic illness care (ACIC) • Patient assessment of care for chronic conditions (PACIC)	• Improved well-being in patients with asthma, diabetes, bipolar disorder, comorbid depression and cancer
INTERACT: http://www.maseniorcarefoundation.org/Initiatives/Care_Transitions.aspx	Nursing home to hospital	• Resource binder for champions • Case examples • Communication tools • Care path and change in condition cards • Advance care planning tools • Quality improvement	• 17% hospital admission reduction • Medicare savings • Further randomized studies to determine: avoidable hospitalizations, morbidity and cost savings

TABLE 2.
Commonalities Among Transitional Care Models

	TCM Transitional Care Model	CTI Care Transitions Intervention	BOOST Better Outcomes for Older Adults through Safe Transitions	RED Re-engineered Discharge	CCM Chronic Care Model	INTERACT Interventions to Reduce Acute Care Transfers
Hospital to home (or nursing home)	X	X	X	X		
Clinic to home					X	
Nursing home to hospital						X
High-risk patients identified	X					
Discharge planning	X	X	X	X		
Discharge instructions	X	X	X			
Medications addressed	X	X	X	X		
Early identification of potential problems	X	X		X		
Written discharge instructions	X	X	X	X		
Follow-up appointment prior to discharge				X		
Tools for health professionals	X	X	X	X	X	X
Patient & family education	X	X	X	X		
Patient-centered care	X	X	X	X	X	X
In-hospital visit	X	X		X		
Home visit(s)	X	X				
Follow-up phone calls	X	X				
Reduced hospital readmissions	X	X	X	X		X
Reduced overall healthcare costs	X	X	X	X	X	X
Improved patient outcomes	X	X	X	X	X	

From Enderlin, C.A., McLeskey, N., Rooker, J.L., Steinhauser, C, D'Avolio, D., Gusewelle, R. , & Ennen, K.A. (2013). Review of current conceptual models and frameworks to guide transitions of care in older adults. *Geriatric Nursing, 34*(1), 47-52. DOI: 10.1016/j.gerinurse.2012.08.003