better health together

Domain 2: Transitional Care

Rationale:

Transitional care services provide opportunities to eliminate avoidable admissions and readmissions. Points of transition out of intensive services/settings and into the community are critical intervention points in the care continuum.

Evidence-based Approaches:

For Care Management and Transitional Care:

- Interventions to Reduce Acute Care Transfers, INTERACT™4.0, a quality improvement program that focuses on the management of acute change in resident condition
- Transitional Care Model (TCM), - a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up
- The Care Transitions Intervention® (CTI®)- a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives.
- Care Transitions Interventions in Mental Health - provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI)

For people with health and behavioral health needs leaving incarceration:

- Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison
- A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model
- American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

System wide Metrics:

- Percent Homeless (Narrow Definition)
- Inpatient Utilization per 1,000
- Medicaid Member Months
- Psychiatric Hospital Readmission Rate
- Plan All-Cause Readmission Rate (30 Days)
- Ambulatory Care - Emergency Department Visits per 1,000 Member Months
- Follow-up After Discharge from ED for Mental Health, Alcohol or
- Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness

Project-Level Metrics: To be determined based on approval of region-specific target populations and selected interventions.