AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

2.b.viii: Hospital-Home Care Collaboration Solutions

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.
2	Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmissions, as well as to support evidence-based medicine and chronic care management.
3	Develop care pathways and other clinical tools for monitoring critically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4	Educate all staff on care pathways and INTERACT-like principles.
5	Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.
6	Create coaching program to facilitate and support implementation.
7	Educate patient and family/caretakers, to facilitate participation in planning of care.
8	Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.
9	Utilize telehealth/telemedicine to enhance hospital-home care collaborations.
10	Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.
11	Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
12	Use EHRs and other technical platforms to track all patients engaged in this project.