Care Transitions Bundle Definitions 2022

4Ms — What Matters, Medication, Mentation, and Mobility — make care of older adults, which can be complex, more manageable. The 4Ms identify the core issues that should drive all decision making in the care of older adults. They organize care and focus on the older adult's wellness and strengths rather than solely on disease. http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

Age-Friendly Health System - Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), designed Age-Friendly Health Systems to meet this challenge head on.

Age-Friendly Health Systems aim to:

- Follow an essential set of evidence-based practices.
- Cause no harm; and
- Align with What Matters to the older adult and their family caregivers.

http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

Beers Criteria Medication List - Potentially Inappropriate Medications for the Elderly According to the Revised Beers Criteria. "Originally conceived by the late Mark Beers, MD (a geriatrician), the Beers Criteria catalogue medications that place older patients at an elevated risk for adverse drug events due to the physiologic changes of aging and concurrent conditions." https://dcri.org/beers-criteria-medication-list/

Color Zone Tools - These downloadable tools were created to assist patients in managing a number of common health conditions. Better self-management can lead to improved overall health and help reduce the chances of hospital readmission. The tools include: Green Zone—All Clear; Yellow Zone—Caution; and Red Zone—Medical Alert.

https://www.hsag.com/zone-tools/

Family (Informal) Caregiver – any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult with a chronic or disabling condition. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care.(Caregiver Action Network) NTOCC uses "the patient's identified family caregiver" in support of the definition developed by the Caregiver Action Network.

Interdisciplinary Care Team (Case Management Study Guide)- By definition, the Interdisciplinary Care Team (ICT) is a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient. Whenever possible the patient and the patient's family should be part of the team.
Members of the Interdisciplinary Care Team may include:

- Physicians
- Nurses
- Case Manager
- Social Worker
- Physical Therapist
- Occupational Therapist
- Chaplain
- Dietitian
- Pharmacist

Interprofessional Care Team - Interprofessional teamwork is the means by which different healthcare professionals – with diverse knowledge, skills and talents – collaborate to achieve a common goal. (RCNiPlus)

Life-Care Plan - The Life Care Plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized, concise plan for current and future needs with associated cost for individuals who have experienced catastrophic injury or have chronic health care needs. (International Academy of Life Care Planners, Standards of Practice)

Medication Management Services (MMS) - - Medication Management Services are a spectrum of patient-centered, pharmacist provided, collaborative services that focus on medication appropriateness, effectiveness, safety, and adherence with the goal of improving health outcomes (JCPP)

Shared Decision Making - Shared decision making (SDM) has been defined as: 'an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445676/

Social Determinants of Health (SDOH) - are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
https://www.ahrq.gov/sdoh/index.html Three tools for screening for SDOH can be found at https://www.aafp.org/journals/fpm/blogs/inpractice/entry/social_determinants.html

STOPP/START Criteria – STOPP)Screening Tool of Older Persons' Prescriptions) and START (Screening Tool to Alert to Right Treatment) are criteria used as a tool for clinicians to review potentially inappropriate medications in older adults and have been endorsed as a best practice by some organizations. https://psnet.ahrq.gov/issue/stoppstart-criteria-potentially-inappropriate-medications-potential-prescribing-omissions

Teach-Back Method - The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand. https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html

Virtual Visits - The American Academy of Family Physicians (AAFP) supports enhanced-access physician-patient interactions, including electronic visits or "virtual e-visits" which occur over safe, secure, online communication systems. AAFP defines a virtual e-visit as an evaluation and management service provided by a physician or other qualified health professional to a patient using a web-based or similar electronic-based communication network for a single patient encounter. https://www.aafp.org/about/policies/all/virtual-evisits.html