Intervention Strategies To Improve Care Transitions

General Strategy	Sub-Strategy	Description	Aim	Targeted Drivers of Readmission
Cross-Setting Care Standard-ization	Enhanced Information Transfer at Discharge	Improvements in timely transfer of medical information from the acute care setting to post-discharge healthcare providers.	• Ensure that current, accurate health information is accessible by receiving providers	• Unreliable handoff processes • Poor information transfer
	Follow-up care established at discharge	Arrangements (made prior to leaving the acute care setting) for the patient to receive appropriate follow-up care.	• Ensure that patients receive proper post-acute follow-up care	• Unreliable handoff processes
	Medication Management	Activities to improve effectiveness of pharmacotherapy; including support of patient understanding of appropriate medication use and adverse events.	• Reduce medication errors leading to adverse events and readmission	• Insufficient support for patient and family self-management • Unreliable handoff processes • Poor information transfer
	Plan of Care	Collaborative development of a complete, accurate strategy for post-discharge care including history, situation, likely progression, and patient/family preferences for end-of-life issues.	• Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers	• Insufficient support for patient and family self-management • Poor information transfer
	Telemedicine	Remote monitoring and care delivery via telemonitoring (electronic or telephonic transfer of physiological data from home to healthcare provider) or regular telephone-based medical management.	• Continued medical management following discharge	• Poor information transfer due to insufficient availability of health information • Discontinuous care after discharge
	Telephone Follow-Up	Telephone calls made to the patient shortly after discharge from the acute care setting to provide information, health education, symptom management, early monitoring of complications, reassurance and quality post-discharge care.	• Address problems arising in the first few weeks following hospital discharge • Address patients' post-discharge questions and care needs	• Discontinuous care after discharge • Insufficient support for patient and family self-management

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	Electronic Health Record/ Electronic Medical Record	Databases and data access/reporting systems to standardize patient information available to providers across care settings.	• Prevent medical errors by minimizing incomplete, inaccurate, and conflicting information across care settings	• Poor information transfer
Systemic Enhance-ments (within setting)	Multi-disciplinary team, Multi-faceted Interventions	Collaboration among a multidisciplinary team, facilitating community treatment, collaborative care and shared primary specialty care.	• Improve care coordination to reduce readmissions • Integration of patients' medical, pharmaceutical, psychosocial and spiritual needs at the time of discharge	• Insufficient support for patient and family self-management • Lack of standard, known processes
	Clinical Protocols, Best Practices, and Regional Guidelines	Establishment of congruence in practice standards within and across settings.	• Ensure that in-setting care will be consistent with care in other settings	• Lack of standard, known processes
	Enhanced Palliative Care Consultation and Support	Improved assessment of palliative care needs and end-of-life preferences, including appropriate palliative and hospice care referrals.	• Ensure common understanding of preferred medical treatments to reduce reliance on acute care services • Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers	• Insufficient support for patient and family self-management • Lack of standard, known processes • Poor information transfer

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Patient, Family, and Caregiver Support	Education	Teaching and materials targeted toward patients, family members and other informal caregivers on topics of disease self-management, treatment options, expectations and available resources.	• Enable patients to avoid unnecessary utilization of health services though accurate understanding of health medical needs • Improve quality of self-care and management.	• Insufficient support for patient and family self-management
	Coaching	Non-medical support for home-based self-management capability.	• Improve competence in achieving personal health goals • Avoid inappropriate and unwanted medical interventions	• Insufficient support for patient and family self-management
	Personal Health Record	Organizational tool for patients to track health care goals/concerns, medications, sign and symptom red flags, provider contact information, and any other information relevant to healthcare self-management.	• Provide reliable resource for patients to document key medical information and track health support needs	• Insufficient support for patient and family self-management • Poor information transfer
	Community Support	Connecting patients and family members to non-medical community health support agencies and other entities within the community.	• Eliminate everyday barriers to self-management (e.g., lack of transportation)	• Insufficient support for patient and family self-management

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