Care Spectrum Plus
COORDINATED CARE FOR ALL

Care Transitions Interventional Table		
Domain Categories	**Description**	**Examples of Interventions**
Medication Management	Ensuring the safe use of medications by patients and their families and based on patients' plans of care • Assessment of patient's medications intake • Patient and family education and counseling about medications • Development and implementation of a plan for medications management as part of the patient's overall plan of care	Assessment of patient's medications intake Medication review including over-the-counter medications, herbals, vitamins, allergies, and drug interactions • Identify problem medications • Identify poly-pharmacy • Adherence and medication schedules Patient and family education and counseling about medications • Teach back method to establish understanding of medication plan • Explain what medications to take, emphasizing any changes in the regimen • Review each medication's purpose, how to take each medication correctly and important side effects to watch out for • Development and implementation of a plan for medications management as part of the patient's overall plan of care Medication Reconciliation including pre hospitalization and post- hospitalization medication lists • Be sure patient has a realistic plan about how to get the medications • Confirm the medication plan - pharmacist follow-up telephone calls after intensive nurse-based patient education upon hospital discharge or transfer • Coordinated and integrated team approach to medication management, involving pharmacists and/or physicians

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Patient and Family Engagement / Education	Education and counseling of patients and families to enhance their active participation in their own care including informed decision making. • Patients and families/caregivers are knowledgeable about condition and plan of care • Patient and family-centered transition communication • Developing self-care management skills Education and counseling of patients and families to enhance their active participation in their own care including informed decision making • Patients and families/caregiver are knowledgeable about condition and plan of care • Patient and family-centered transition communication • Developing self-care management skills	• Patients and families/caregivers are knowledgeable about condition and plan of care • Patient is knowledgeable about indications that their condition is worsening and how to respond using knowledge of “red flags” • Provision of education using appropriate health-literacy materials and language • Use of patient and family education and counseling guides Patient and family-centered transition communication • “Translating” information between the provider and patient to ensure that each really understands what the other has communicated • Conducting real time patient- and family-centered handoff communication • Developing self-care management skills • Improving patient and family education practices to encourage use of the teach-back process around risk specific issues • Assess the patients’ degree of understanding by asking them to explain the details of the plan in their own words
Information Transfer	Patients and families/caregivers are knowledgeable about condition and plan of care • Patient is knowledgeable about indications that their condition is worsening and how to respond using knowledge of “red flags” • Provision of education using appropriate health-literacy materials and language • Use of patient and family education and counseling guides Developing self-care management skills • Improving patient and family education practices to encourage use of the teach-back	Implementation of clearly defined communication models • Communication infrastructure, that will enhance communication with other healthcare providers about a patient (or resident in certain settings) change of status • Timely feedback and feed-forward of information by utilizing specific communication models that support consistent and clear communication among healthcare practitioners and caregivers Use of formal communication tools • Use of personal health record

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	process around risk specific issues • Assess the patients' degree of understanding by asking them to explain the details of the plan in their own words	
Follow-Up Care	Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up care activities. Patients and families timely access to key healthcare providers after an episode of care as required by patient's condition and needs Communicating with patients and/or families and other healthcare providers post transition from an episode of care	Patients and families timely access to key healthcare providers after an episode of care as required by the patient's condition and needs • Confirmation of Primary Care and Specialist Follow-Up • Make appointments for clinician follow-up and post-discharge testing prior to discharge • Post-acute care follow-up, including a face-to-face visit at home and/or with a doctor, within 48 hours of discharge • Enhanced access and not having long wait times to get in to see a provider Communicating with patients and/or families and other healthcare providers post transition from an episode of care • A primary-care RN to call the patient by the next business day to monitor his or her condition. • Telephone re-enforcement of the Discharge or Transition Plan and problem